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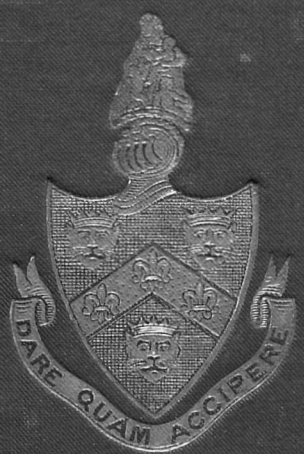

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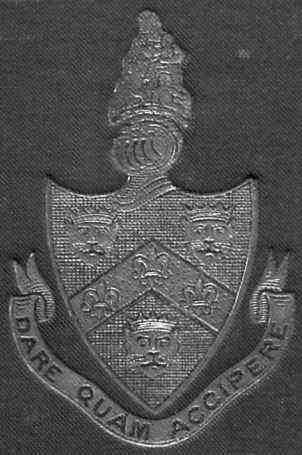

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Passim.

IT was with great regret that we heard of the death of Professor Debus. It was in 1870 that Dr. Debus, as he was then called, left Clifton College, where he was Lecturer on Chemistry, and came to Guy's to take up a similar position. This he held for eighteen years, and his admirable capabilities as a lecturer, together with his kindly face and courteous manners, endeared him thoroughly in the hearts of the students. They always took their hats off to him most respectfully, and he always, as he entered the hospital gates, raised his hat and kept it so till he reached his laboratory, which stood where the new Bacteriological Department now is. In the lecture theatre he always managed in each course to introduce the subject of "smoke-rings." For that purpose he used to smoke a cigar, and demonstrate beautiful rings to his enthusiastic audience.

CHRISTMAS has come and gone once more, and the New Year draws near. In former years it has been our Editorial habit to wish our readers a "Happy New Year," but so many of them are scattered over the world in places where happiness is impossible without danger, that we feel we must break the rule and wish them the "Best of Luck" instead.

Christmas festivities have been carried on with that vigour and merriment which marks any diversion from the usual routine of Hospital life; although enacted on a smaller scale, they have given the organisers just as much excitement, just as much merriment, and now that they are nearly over, just as much fatigue as in former years. Sisters and Nurses have decorated their wards with as much zest as ever. Patients have twisted paper-flowers for an agile House Officer or Student, perched upon a rickety ladder, to fasten to lamp shades and brackets. The usual number of posters in the Colonnade to announce Ward Concerts were not, however, forthcoming, possibly because the Hospital's premier artist is on active service.

On Christmas Eve, the Niggers, at the invitation of Mr. Fagge, gave a performance at the Mount Vernon War Hospital. The wounded Tommies gave them a hearty welcome, and, to judge from their faces, enjoyed the programme thoroughly.

Christmas Day saw the College Quadrangle filled with rowdy figures, dressed in weird and wonderful garbs, and the usual crowd from the Borough outside the College door, who had come to see the "doctors a going h'on·"

At twelve o'clock the Niggers were ready for the fray. After some delay, while throats were cleared in time honoured fashion, Massa Johnson (President C. Dean), disguised as Charlie Chaplin, led his merry men across to the Colonnade steps where the customary photograph was taken. "Eyes" was the first ward to be visited, and "Massa Nibbie," as the irrepressible school boy, opened the programme. Ward after ward was visited till they reached "Out-Patients." Here the Landon Christ-

mas Tea was in full swing and the Niggers were accorded a huge reception, chiefly taking the form of paper balls and apple cores, but still it was worth seeing, it is not often that one sees seven hundred Borough children enjoying themselves so thoroughly. Clinical and Surgical Wards next claimed the Niggers. Massa Stallman, as Peter Doodey. brought the house down with his song, "My Motter," which he rendered in an admirably blank monotone. It was nine o'clock before the Niggers trooped out of Astley Cooper Ward, after providing the Hospital with an excellent programme. Massa Curle is to be congratulated on having collected such a fine troupe, especially in times when it must have been very difficult to arrange regular practices.

As was the case last year, there have been no Residents' Theatricals, and unfortunately it was also found impossible to arrange the concerts which were held with such success in the Physiological Theatre last year.

Ward concerts have been going on all the week, and the Hospital is indebted to those artistes, who have come so kindly during the week to entertain the patients and ourselves.

ON Wednesday the Niggers were invited down to Queen Mary's Hospital, Southend, by Dr. Hale White. A performance lasting over two hours was given, ending up with a procession through the wards.

WE would like to offer our hearty congratulations to those Guy's men whose names were included in the latest list of Military Awards, which will be found on another page.

IN our last Xmas issue of the GAZETTE, an appeal was made for prescriptions and formulæ for the new edition of the Guy's Hospital Pharmacopœia. We are pleased to be able to announce that *at any moment* this might be published, probably before the end of this month. Five thousand copies will he printed, and the net prices will be as follows :—Bound in cloth, 2s.; bound in leather, uninterleaved, 2s. 6d.; bound in leather and interleaved, 3s.

Obituary.

HENRY FRANCIS THOMAS HOGBEN.

HARRY HOGBEN received his early education at Bedford Grammar School, and entered Guy's in October, 1909, winning the London University Open Scholarship. He passed his first M.B. examination in July, 1910, and entered the wards in October, 1912. Amongst his appointments he was Medical Ward Clerk to Sir Cooper Perry, and Dresser to Mr. Steward,

At the outbreak of war, he was working for his final examination, but as he already held a commission in the 10th Middlesex, he had to forego his studies and answer to the Mobilisation Order.

After training in England for two months, his regiment was ordered out to India in October, 1914, in which country he remained till August of this year. He wa then selected to take a draft from the 10th Middlesex t the Persian Gulf, where he became attached to the 2nd Norfolk Regiment. He fell in an action in which his regiment was engaged between the days of November 22nd and 24th.

During hls life at Guy's, Harry Hogben, was a Member of the Artist Rifles, was a keen Territorial, whilst his skill as a marksman was envied by all his pals. At Bisley he achieved many successes, and was in the King's Hundred in the years 1913 and 1914. Amongst other sports, he represented the Hospital as a "heavyweight," and was always a regular man to turn out for a game of "Rugger."

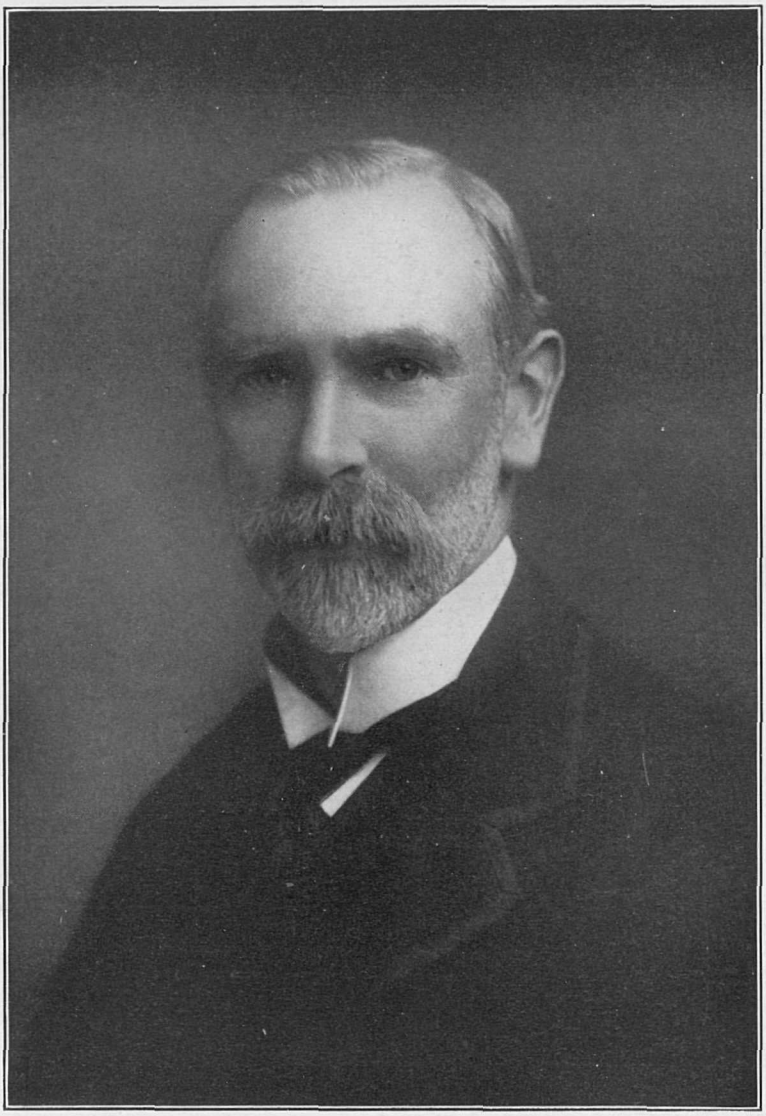
And so, the Alma Mater has to mourn the loss of another of her sons, one who, on the point of qualifying, gave up all—and right willingly too—for his King and Country.

TO HIS PARENTS.

COPY OF LETTER WRITTEN 11/10/15.

Indian Expeditionary Force "D,"
Azizieh.

We were now at a place called Azizieh, about 50 miles from Bagdad. My last letter was written from Sunnaiyat, which was our last standing camp. On 24th September we experienced the joys of a dust storm, which enveloped us all day. Everything was gritty, even my eyelids when I winked! The next morning the enemy introduced us to a new form of frightfulness, by bringing a couple of guns down the river and shelling the camp at 4.45 a.m. Casualties one mule killed, one tent pole severely wounded. The next morning we left Sunnaiyat for the advance on Kut-el-Amarah, our kit being reduced to one blanket and what we carried on us. This was Sunday, we advanced a few miles up river and disembarked just out of range of the enemy's heavy guns. They spent all that day and part of the night trying to reach us, but failed. On Monday we (18th Brigade) advanced to the centre of the enemy's position to occupy his attention while the 16th and 17th Brigades



RICHARD ASSHETON, M.A., Sc.D., F.R.S.

Born 1863. Died 1915.

Lecturer on Biology, 1901—1914.

Lieutenant H. F. T. HOGBEN,

Killed in action whilst attached to the 2nd Norfolks, serving at Mesopotamia, on November 23rd, 1915.

Educated at Bedford Grammar School and Guy's Hospital.

did a flank march. We soon came under shell fire, and after a time I was unable to advance further with my platoon, so we halted and commenced to dig for all we were worth. It was necessary too, for the Turkish gunners had our range to a yard, and plastered us with shell. One man was wounded in the trench, such as it was, and when we did advance a shrapnel caught us squarely just as we were leaving the trench, and killed my sergeant a few yards away from me. No one else was touched. I then got up to the second line with the rest of my company where we lay for the rest of the day with the sun blazing on us, and terribly little to drink. That night as soon as it was dark, we began to dig again, a little nearer the enemy's position. That night we did not even have our one blanket, and as the nights are now bitterly cold you can imagine our sleep was hardly refreshing. Next morning the other two brigades made their attack while our guns shelled the enemy's position from our rear. The Turks had a lot of guns and gave us a tremendous shelling and the noise was terrific. I was so tired though that I slept through two hours of it in the morning. The 16th Brigade finally crumpled up the enemy's left, and those in front of us had to go or they would have been caught in the rear. This they did during Tuesday night, and on Wednesday morning we walked up to their barbed wire and through it to the trenches beyond. They had a most magnificent position which we could never have taken by a frontal attack, and I am glad we did not have to try. That evening we moved over the river again and re-embarked for the pursuit, and I had my first wash since Saturday morning. You cannot imagine what awful objects we looked, unshaved, unwashed, inches deep in dust which had caked to mud where we sweated, and woefully tired. Well, a bath and a shave worked wonders, but I still feel tired, I should so much like to sleep in a bed in pyjamas once more. The ground is very hard and I am tired of my clothes too, but still I can stick it all right, you need not worry about that and I shall enjoy the rest all the more when I get it. This is a miserable letter and I am afraid it will bore you, but I do not feel in my best vein for scribbling to-day. I have not had a home mail for nearly three weeks and goodness only knows when they will reach here, but I live in hopes. It takes a letter longer to get from Basra to here than from Sunderland to Basra now. The river is low and so few boats are available. Well, I must say good bye now and lots of love to everyone . . . . Chocolate will be most frightfully acceptable now that the cold weather is on us.

Indian Expeditionary Force "D,"
Azizieh, 21st October, 1915.

There is nothing fresh to tell you since my last letter which I had intended to be a glowing description in my best style of my first impressions of war at close quarters. However, I was so tired and had so little time that I fear it was but a poor scrawl you received. We are still at Azizieh, very hard worked as there is a tremendous amount of digging to be done, and outpost work is almost continuous. The latter is very trying, and the nights are now so cold and the sandflies are maddening. They are something like the midges at home and can get through any mosquito net, and their skill at finding uncovered spots is simply amazing. In addition to all these worries we ran out of nearly all our mess stores, and were reduced to tea without milk and ration rum our only drinks. Of course we have only tinned milk at best of times, but even that is better than none at all. I have had two mails during the last month, yours of the 26th August and 3rd September. The river is so low that mails are dreadfully uncertain, and we exist largely on hopes of one coming. We are now anxiously awaiting the arrival of our winter kit, and when that comes life will be more bearable. At present you can picture me standing at arms at 4.30 a.m., with a blanket over my shoulders, a couple of handkerchiefs round my neck, and a pair of socks doing duty as gloves, stamping up and down and trying to keep warm, and yet at noon it is so hot that one is glad to seek shelter in a double-fly tent. The enemy have hardly worried us at all since we came here, though they have a strong force only 12 miles away. Their cavalry and ours have a scrap every morning, but neither side gets much hurt. Our chief enemy now is the climate and the sickness among the men is dreadful. Of course most of them have been in this filthy climate for a whole year now, and they have no reserve forces to fall back upon. I do not think this battalion could put more than 350 men in the field now and they came out last November 1,100 strong, and have had drafts amounting to over 400 since. That will give you some idea of what a "Cook's" Tour this campaign has been. I am quite sure that the hardships the men have undergone in Mesopotamia have been worse than any other campaign, taken all round, for there is no such thing as "leave" from this country and the climate is poisonous, there is no other word for it. Please do not think that I am making out a case for myself, for I have only had five months, but those who have been out here all the time deserve well of the people at home who, I am afraid, think only of those in France and at the Dardanelles. At least that is the impression one gets from the home papers. Of course you are not told much at home about doings out here, for some inscrutable reason. I am sorry that you should have worried over getting no news from me, but you can always assume that no news is good news, and that you would be informed by cable if anything happened to me. The battalion of ours in the Dardanelles is the 2/10th. We in India are the 1/10th; they are still in Calcutta and are dreadfully bored with life there. I get plaintive letters from Fisher and others from time to time which make me glad I got away from it all, in spite of the manifold discomforts of this life . . . . Well, I cannot think of anything more, so must close now. I am very well, though I was down with fever for a couple of days, due to sandflies I think . . . . My love to all the family.

L'espion Malgré Lui.

III.—THE RETURN.

"Misery acquaints a man with strange bedfellows."
—The Tempest, act ii., scene 2.

Albergo della Stella Bianca, August 15th. I think it was the German historian, Von Raüben, who said of the people of Naples that "they were created before the fuss arose concerning the seven deadly sins," and certainly from my eyrie on the fifth story of this atrocious hotel I get a good, if somewhat inverted, view of the truth of his remark. They tell you that May is the month of asses, but here, in the dusty purlieus of the *Sezione Vicaria*, the beasts bray all day long, raising their voices in an agony of protest against the stench and tropic heat. To-day the city air is heavy with a mortal languour. The promise of coming *scirocco* hangs like a doom under which men fret, curse, and perspire. Breath itself down in those streets so full of noise—the clanging of bells, the rumble of wheels on the cobbles, the thousand idle cries of the populace—becomes a labour of Sisyphus, a useless prolongation of the intolerable burden of living. Yet, beneath the inscrutable silence of the heavens, they seem to dwindle till the final impression is one of ominous calm, like the moment of suspense which precedes the bursting of the hurricane, the crash of the thunderbolt. From my balcony I can see the summit and sides of Vesuvius crowned with a clinging, grey vapour. The sea, black and oily, lies without a ripple, like a crouching beast. The beating of its pulse amongst the slimy rocks round the harbour leaves unheeded the light breeze which troubles its surface in rippling curves. The air from it strikes the face with a sensation of stifling heat, like a gust from some lazar-house. The mind becomes charged with the feeling of a vast impurity in nature, like the recollection of an outworn passion lurking amid heavy draperies and stale perfumes.

In the dim alley-ways where one plunges at first into a cool twilight after the tawdry brilliance of the streets, the crowded passages swarm with a life that seems the more vital in contrast with the general stagnation. A thousand odours assail the nostril, and pass, leaving the senses paralysed by their multiplicity. Sitting beneath an archway a beggar searches for vermin. The atmosphere is one of teeming fecondity, the air resounds with the cries of innumerable offspring. Scantily-clad ragamuffins play and quarrel in the garbage. Countless mothers offer the breast to naked infants. Elder sisters poise thoughtfully, comb in hand, over the polls of their younger brethren. Pausing a moment in the doorway of a *stiratoria* (ironing shop) one notes the almost Praxitelean beauty of some of the workers, the soft and regular features, the rounded archness of the arms, the well-formed bust. A hobbling, bearded old hag stops for a moment, and is greeted with a rattling fire of chaff and abuse from the laundresses. To a jaded eye they seem the quintessence of womanhood, fools subtly baited for the immolation of fools upon the altar of an incessant maternity. A countryman guiding a lumbering wagon charged with wine-casks mutters a litany of curses at his sweating beast. The sellers of baked nuts, fancy mirrors, and rosaries, the vendors of artichokes, ices, *koko*, the day's songs, rend the din with their particular clamour. A pedlar, bearing ridiculously suspended from his person plaster casts of Dante, Cupid and Psyche, Garibaldi, and the Boy with a Thorn, passes from door to door, sustained by a foolish optimism. There is little here of beauty, but the sincerity of its realism relieves the view from utter horror.

Naturally at this season everyone who can do so leaves Naples for the mountains or one of the summer resorts which abound on the borders of the Bay. True, the exodus this year has not been so universal owing to the war, but most of my friends have departed, and I am left practically in solitude, confined under police surveillance till I can be removed from the country. The circumstances of my removal from Capri, in spite of my proved innocence, resembled those of a convicted felon. About three days after the arrival of the official notice of my acquital, a second telegram came from Rome ordering me to be "conveyed" (trascinato) from Capri to Naples. At 5.30 a.m., accordingly, on the following day I was conducted to the harbour under the escort of two of local police, armed with stilettos and revolvers, and looking, in spite of their elaborate plain-clothes get-up more like policemen than I imagined previously was possible. Very pleasant it was to breathe the fresh morning air after my three months' confinement. The vivid colours of the vineyards and olive groves, the fresh distances of the Bay lying so cool and inviting in the wakeful air. As our cab lumbered down the long descent to the Marina Grande, we passed little groups of two or three, clustered round the basin of some spring or chaffering with a fisherman toiling up the winding road with his night's catch. who stopped to gaze and point at the *Inglese*, who was doubtless going to his trial. My escort was amiable enough, and soon we were exchanging compliments and cigarettes, and a little banter on the methods of Italian justice. It was only on my arrival at Naples that I began to scent fresh complications. After an interminable wait in the corridors of the Questura, I was ushered in to interview a minor official, in charge of the foreign department. A long discussion followed in which it was decided that if the English Consul would make himself personally responsible for my conduct till I could leave Naples, I was to be allowed liberty of the ticket-of-leave order, otherwise I was to be kept in confinement, in spite of the fact that I

had been proved innocent, or rather released for want of any evidence against me. Awaiting the Consul's response I was placed along with a number of other unfortunates in the guardroom. The methods of Italian procedure were well exemplified in their treatment of the poor wretches who every few minutes were dragged in by a couple of *carabinieri*. A bullying sergeant of police, seated at an imposing desk surrounded by racks of muskets and handcuffs, roared threats and questions; the two who had effected the arrest for some trifling misdemeanor shook the culprit; most of them were small boys who had been caught blacking boots or selling picture postcards without a license. A long deposition was taken, or, rather, pretended to be taken, the personal property of the culprit confiscated, and he marched off to the cells. A London constable may not invariably be irreproachable, but he is a model of deportment and *sangfroid* in comparison with these excitable Dogberries. A Russian doctor sat waiting with admirable patience—he had been there since nine o'clock and it was now late afternoon—for some trifling piece of red-tapery, which neither he nor anyone else appeared to understand. The heat grew more and more stifling, the sergeant more irascible, the constables more drowsy. I thought of the Bay as I had seen it in the early morning, and the burden of its cool invitation became almost intolerable. Outside in the street a youth sang a song which seemed to mock us in its lightness :—

**Riscaldata la stagione*
Incomcia il sol'leone!
Giovannotti, andate a mare
Andatevi bagnare!
Il mare sedduttore
E una trappola d'amore,
E la donna e una syrena,
Che nel mare v'incatena.
Giovannotti, andate a mare!

Suddenly the somnolent afternoon was revived with a splash of unwonted colour. A sound of lively protest was heard in the courtyard and a couple of sweating constables piloted in four or five women all more or less hysterical. Their handsome dark faces were dust-stained and relieved only by the brilliant line of the teeth showing in chiaroscuro against the dark outline of their hair. Their gaudy head-dress is a little tumbled, one of them bears a child in her arms. The offence is simple enough, they are vagrants, *zingari*, found wandering about without the necessary *permesso*. But the sergeant is non-plussed. The only language they speak is Serbian—they hailed, I found, from Podgoritza — and the gift of tongues is not his. The Russian doctor is called in consultation ; he and I interrogate them. By slow degrees we elicit the fact that their husbands and brothers have gone off to fight, and they are left in a foreign land without resources. With typical Italian logic the sergeant orders their incarceration. "They are the scum of the earth!" says he, in answer to our protests. So with handshakes and *S'bogom's* (God be with you) for the Russian and myself, whom for some reason they seemed to regard as their deliverers, they were led off to the cells. "What are you going to do?" I asked the sergeant. "Oh," he said, "we shall write to Montenegro to take information about them." As at that time postal communication with Montenegro took upwards of two months, they are probably in for a pleasant time. Which reminds me of the story of a Professor from Uruguay I met the other day who had been interned as an enemy alien, because the sergeant or some clerk or other had not known the difference between Urughia and Ungheria (Hungary). About six o'clock came the message that as the English Consul knew nothing of me he could enter into no guarantee as to my conduct. I suggested telegraphing to my good friend the Vice-Consul at Capri, but no, Naples is not his district, and my plea that the guarantee of a Consul who knew me was likely to be of more value than one who did not, was pooh-poohed as mere sophistry. "But," says the official, "we will do everything for your comfort; you shall have a room in a good hotel, and though I am afraid we must keep a watch on you, it will be only for a day or two till it can be arranged to escort you from the country." So I was conducted away by devious bye-paths to the lowest quarter of the town, a cobbled street facing on the docks, and filled by day with the cries of wailing children, and by night with the brawls of the cosmopolitan crowd who man the ships of this huge port.

I have been here a week now and am regarded as almost a fixture amid the shifting denizens of this "*dernière asile des miserables.*" It is a sort of Salvation Army Shelter for the vast indigent population which tramps over Italy in search of change and sunshine. The police with painstaking ingenuity track them out, take them in charge, and keep them here till their own police at home are communicated with, and they are sent home. A veritable *wanderlust* seems to attack all sorts of unlikely people. An elderly dressmaker made her way here from Milan for no reason at all that I could discover and was picked up by the police, fainting for want of food. A little Italian lad of fifteen ran away from Avignon where his parents pursued the lucrative occupation of *chiffoniers*, as a stowaway in a coal tramp, and has been here two months awaiting the arrival of his fond papa. A maiden of even more tender age was brought here the other night wandering about in search of a soldier lover, who, she said, was off to Tripoli. The Uruguayan professor and I have struck up a great friendship and spend our time fulminating against the

*The season's growing warm, the dog-days have started. Go to the sea, young fellows, go and bathe! For the seductive sea is one of Love's ambushes, and woman a syren, who in the sea will enchain you. Go to the sea, young fellows, go and bathe!

government and trying to understand D'Annunzio. The docks are very dingy, and in the stagnation which the war has caused the dockers have little to do but patronize the itinerant vendors with which the streets are filled. Wonderful schemes of chromatic contrasts, these barrows. The vermilion, paling through amber to green, the strange fantastic shapes of the *piperone*, the carmine of the egg-plant, the hectic peaches, the russet and crimson of the *albicocche*. Old women squat in corners turning piles of early walnuts from emerald to umber, barrows loaded high with dandelion and endive are further notes in a restless symphony. Others sell gaudy fans, iced lemonade, straw hats; long trays are charged with translations of bad French novels, and here and there a little gem by Verga or the Sardinian authoress Grazia Deledda. It is infinitely entertaining, this gay, insouciant life of the streets where nothing matters but noise and brightness. Soon I shall be leaving it, for there is news of a steamer which will take me to Marseilles, and from there I have been planning a pilgrimage to the sun-brown cities of Old Provence: Nîmes, Arles, Tarascon, Oranges, Avignon, Aigues Mortes. I have been toying with their names all day; juggling with them, transposing them. Yet, perhaps, when I see for the last time the long grey shape of Ischia, fading in the sunset, it will be with a feeling of regret. All day long a triolet by some poet of the Renaissance has been running in my head—

Li departir de la dolce contré,
Ou la belle est,
M'a mis en grand tristor."

Perhaps my departure, too, for all that I have suffered, will put me "*en grand tristor.*"

G. H. F. G.

Change of Address.

Lieut. H. Mather, R.A.M.C. Mess, No. 2 Camp, Sling, Salisbury.

V. Glendinning, M.S., F.R.C.S., 4, Mildred Avenue, Watford.

A. F. Salisbury, L.D.S., Woodbourne, Knoll Road, Camberley.

Capt. W. P. Henley Munden, R.A.M.C., M.O. I/C 16th Service Battalion Sherwood Foresters, 39th Division, Witley Camp, Surrey.

2nd Lieutenant J. H. E. Winston, 3/5 Yorks Regiment, The Manor Hotel, St. Nicholas Cliff, Scarboro.

Lieutenant H. F. Vandermin, R.A.M.C., from Silverton, Enfield, to 28 General Hospital, British Force in Greece, Salonika.

Capt. Arthur Tilbury, R.A.M.C., from The Barracks, Canterbury, to M.E.F., Boulac Palace Hotel, Cairo, Egypt.

Appointments.

Royal Army Medical Corps.

The undermentioned have been appointed temporary Lieutenants :—D. W. Jones, F. J. Lidderdale, H. B. Wilkinson, W. E. Plummer.

To be temporary Captains :—N. H. Oliver, N. P. H. Munden.

Civil.

R. A. Greenwich, M.B., B.S. Lond., F.R.C.S.Eng., has been appointed Assistant Surgeon to the Royal London Ophthalmic Hospital, Moorfields, E.C.

Pass List.

University of London.

M.B. (Part II.).—At the examination held recently the following candidates were approved :—Oliver St. Leger Campion, Walter Henry Grace, Walter Alan Flynn, Robert Louis Portway.

M.D., Branch I.—Erulkah Abraham Soloman, B.S.

Royal College of Surgeons of England.

The Licence in Dental Surgery has been conferred upon the following candidates who have passed the requisite examinations and complied with the necessary by-laws :—George Dee, Arnold Thomas Densham, Edward Percy Deverall, Maurice George Henry, Cyril Randall Martin, John Lisle Mugford, Harry Laurence Thorn, Graham McRim Thomas, Roger Gilbert Wilshere.

Roll of Honour.

The following honours for distinguished and meritorious service in war have been awarded :—

C.B.—Col. F. F. Burghard.

D.S.O.—Major C. R. Evans, Major V. J. Crawford, Captain J. W. Bird.

The Military Cross has been conferred on Lieutenant W. K. Fry.

Papers by Guy's Men.

M. T. Hicks, F.R.C.S. : Ruptured Tubal Gestation resulting in hæmorrhage into the general peritoneal cavity.—*The Clinical Journal*, December 15th, 1915.

Capt. H. G. Gibson, R.A.M.C. (in collaboration with Lieut.-Colonel D. Harvey, R.A.M.C.) : Some Experiments on the antibody production in rabbits with mixed typhoid, paratyphoid, and cholera vaccines.—*Journal of the R.A.M.C.*, November, 1915.

David Forsyth, M.D., D.Sc., F.R.C.P. Lond. :—Functional nerve disease and the shock of battle.—*Lancet*, December 25th, 1915.

Lichen Planus and Psoriasis.

By H. W. BARBER, M.B., M.R.C.P.

I HAVE recently had under my care at the Prince of Wales' Hospital two girls—one with lichen planus, the other with psoriasis. I have never seen cases in which the diseases were so extensive as in these two patients, and a short account of their progress under treatment may be of interest.

CASE 1. *Lichen planus.*—The patient is an attractive-looking girl in the early twenties. Her health was good until May, 1915: at this time she lost two of her brothers at the front in the course of a week. Only a few days later a rash began to appear on her wrists, forearms and thighs. She was treated for some time by a doctor, and afterwards came up to the Prince of Wales' Hospital.

When I saw her the rash was very extensive, involving the arms, legs and trunk. Careful examination showed that all the types of papule, differentiated by Unna—the polygonal, the obtuse, the plane, and the acuminate—were present. On the lower part of the back, the abdomen and thighs very large patches, formed by the agglomeration of the papules, were found. The mucous membrane of the mouth did not seem to be affected. The patient complained greatly of the itching, which prevented her from sleeping.

I prescribed a mixture containing iron and arsenic, and a cyllin ointment (cyllin ʒss., acid. salicylici gr. x., hydrarg. ammon. gr. v., paraffin moll. ad. ʒi.), telling the patient to attend regularly every week in order that the dose of arsenic might be gradually increased. For some weeks some improvement took place, and the itching was considerably less. Fresh papules, however, began to appear on the chest, and, although I realised that the rash would probably not begin to disappear until large doses of arsenic were being taken, I decided to admit the patient into hospital, where she would be free from the depressing influence of a bereaved family, and subjected to prolonged rest in bed. The arsenic was continued as before in increasing doses, but, instead of the cyllin ointment, I ordered the following, a favourite one with Unna:—

℞ Hyd. Perchlor. ... ... gr. iii.
Acid. Carbolic ... ... gr. xx.
Ung. Zinci ... ... ʒi.

In addition, cyllin baths were given every day, and a generous diet instituted.

Under this treatment improvement became evident in a week, not only as regards the eruption, but also in the general condition of the patient. Some time later, however, she complained that the itching was severe at night, and prevented her from getting to sleep; a draught containing fifteen grains each of pot. brom. and chloral hydrate was therefore given at night time, and this afforded complete relief. When the dose of arsenic had reached twelve minims of Fowler's solution thrice daily, the drug was discontinued, and, as the skin was becoming rather harsh and dry, Unna's ointment was replaced by the ung. glycerini plumbi subacetatis. By this time most of the recent papules had completely disappeared, and the older patches on the limbs and trunk were undergoing involution, leaving a deep bluish-brown pigmentation. The follicular or acuminate lesions, however, were still very marked in certain places, especially on the extensor surfaces of the limbs.

A mixture containing cod liver oil and iron was then given instead of the arsenical one, and the sleeping draught abandoned. The patient's appetite improved greatly, and she was encouraged to eat as much as possible. A fortnight before Christmas she was discharged, the actual eruption having almost disappeared; the pigmentation left by the patches, however, was still intense.

Comments on the case.—The onset of the disease seemed to follow almost immediately upon the news of her brothers' death. We are entirely ignorant of the actual cause of lichen planus, but its association with shock, profound grief, and worry is so frequent that it cannot be explained as a mere coincidence. Nevertheless some cases give no such history, and seem to be in good health.

This particular case was remarkable for its severity and the great extent of the eruption; also, perhaps, because every type of lesion was present at once. The follicular or acuminate papules were at one stage extremely numerous, the condition well meriting Dr. Pringle's term "Lichen plano-pilaris." The intense pigmentation resulting from the eruption was very striking, being more evident, I think, than I have ever seen before. It is more than probable that the arsenic was partly responsible for this, as it certainly is very often in the case of pigmentation following psoriasis.

As regards the treatment, there is no doubt that arsenic given, as in psoriasis, in gradually

increasing doses is of great value, but usually improvement does not show itself until considerable doses are being taken. In cases of severity I am of the opinion that complete rest in bed should always be strongly advised, if not insisted on. In this particular case removal of the patient from the atmosphere of domestic sorrow, together with rest and a generous diet, were, I am sure, responsible to a great extent for her rapid improvement in hospital. Local treatment with ointments, though of value, does not seem to be nearly so important as it is in psoriasis. My patient expressed a great liking for her cyllin baths, but I cannot say if they did any good. I have not tried Jacquet's plan of giving tepid douches, followed by momentary cold ones, but I can well believe in the value of their tonic effect.

CASE 2. *Psoriasis.*—This was certainly the most extensive case of psoriasis I have ever encountered, though I have lately seen two more which run it very close. The patient was a girl of eighteen, with the fair hair and fresh complexion usually associated with the disease. She was literally covered with the eruptions from head to foot when I first saw her, and, although she had had previous attacks, she had never experienced anything like the present one. It was at once evident that she must be admitted into hospital, and I therefore engaged a bed for her.

Her scalp was covered with thick crusts, and her face with numerous scaly patches; on the trunk, back and front, the eruption formed almost one continuous sheet, so that it would have been difficult to put one's finger on a healthy piece of skin. The thighs were in almost the same condition, and the extensor surfaces of the arms and legs were covered with patches on which the scales were heaped up in limpet-shell fashion. The patient's general condition was fairly good, though she appeared somewhat anæmic.

The first indication for treatment was obviously to remove the heaped-up scales; she was therefore ordered prolonged alkaline and tar baths, followed by the application of a salicylic acid ointment (10 gr. ad. ℥i.). For the face the ung. hydrarg. ammon., with 10 gr. of salicylic acid to the ounce added, was employed; to the scalp starch poultices were first applied, in order to soften the crusts; it was then shampooed frequently with spirit soap, and the same ointment as was being used for the face was rubbed well in night and morning. Internally a mixture containing three minims of liq. arsenicalis was prescribed thrice daily, and the dose of arsenic was subsequently increased every week. When the scales had been satisfactorily removed the ung. olei. cadini was applied night and morning to the limbs and trunk, and cyllin baths were given every day.

Great improvement was manifest at the end of a fortnight; the patches on the face had disappeared, and the scalp was comparatively free from scales. Considerable areas on the trunk and limbs showed signs of involution, but there were patches, especially on the lower part of the back and abdomen and on the thighs, which were considerably thickened and resistant to treatment. It was therefore decided to employ a chrysarobin ointment, and one containing ten grains each of chrysarobin and salicylic acid to the ounce of soft paraffin was directed to be rubbed into these patches once daily. At the end of a week the usual well-marked erythemia had appeared on the healthy skin, while most of the diseased areas had either disappeared or had become white: a slightly stronger chrysarobin preparation was then used for the still resistant patches, while ung. zinci was spread on the erythematous skin.

When the patient was eventually discharged, after being some seven weeks in hospital, there was practically no active disease present, but she was told to present herself at Out-patients from time to time, in order that any signs of recurrence might be dealt with at once. It may be of interest to mention that a few weeks after her discharge a younger sister came to Out-patients with a mild attack of psoriasis. There is but little evidence in support of the view that the disease is directly contagious, but I believe that its occurrence in two or more members of the same family is more frequent than is usually supposed. I know of one family in which the father and his three daughters are all affected. Quite recently I saw a baby of six months with well-marked and unmistakable psoriasis, which had already been present for three months; on examining her sister, aged five, I found that some of her nails presented the peculiar punctate pitted appearance, which, if well-marked, is almost characteristic of the disease, though I could find no patches elsewhere.

Since we know very little more as to the actual cause of psoriasis than in the case of lichen planus, its treatment is almost purely empirical. Arsenic, except in very acute or developing cases, is almost always indicated, but it must be given in increasing doses, very often until 30–45 minims of Fowler's solution are being taken daily. Chrysarobin is the ideal

local application if the patient is in hospital or under close supervision, and it may also be prescribed to out-patients in weak preparations, provided proper directions as to its use are carefully given. In my opinion the ointment recommended by Unna is the best, viz.:—

℞	Chrysarobin	2—5	parts.
	Ichthyol	5	"
	Acid Salicyl	2	"
	Paraffin moll. add. ...	100	"

It the patches are few in number, chrysarobin paint is a useful and cleanly preparation, *e.g.*, ʒi of pure gutta-percha is dissolved in ʒx of chloroform; to this ʒi of chrysarobin is added, and the mixture painted on the patches after removal of the scales. The X-rays can often usefully be employed, For example, I have under my care now a school-teacher who had an extensive eruption, and she was very worried because the backs of her hands were affected. A few half-pastille doses of X-rays sufficed to cure the hands, and the remainder is clearing up with the use of tar ointment and arsenic internally.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

DEAR SIR,—May I ask for the kindly interest of your readers in our Maternity Charity? Writing from the Headquarters of the "Nurses' Side," as described by the initiated, old friends may be glad to have their memories refreshed, and new subscribers be pleased to read a short explanation of the history of our work and its method of procedure. From a large area of the Borough of Southwark, stretching from the "Elephant and Castle" to Bankside, and bounded by Boro' High Street and Waterloo Bridge Road, expectant mothers may apply at Guy's Hospital Out-Patient Department for a card which entitles them to the services of a nurse to attend them at the time of their confinement, and to visit them, in normal cases, for ten days afterwards. In abnormal cases the visits are continued, and all necessary treatment carried out, until the patient is well or suitable arrangements have been made with other authorities.

For some time seven pupil midwives, who are all fully trained and certificated Guy's Nurses, have been engaged in this work. They live in St. Thomas's Street, and are under the direct supervision and instruction of a certificated Midwife, who also has a certificated assistant to relieve her of alternate night duty and to help generally with the more serious cases.

The Midwife-in-Charge is directly responsible to the "Charity" (a Resident Medical Officer at Guy's Hos-Hospital) to report on and to obtain immediate assistance for all cases of abnormal labours, or any illness in mother or infant requiring medical aid. It is, of course, a great advantage to the Mothers our Nurses attend that they are in touch with the Hospital in their own neighbourhood. At the direction of the "Charity" they can be admitted to "Victoria," our Maternity Ward, when their condition demands it. During 1915, up to the end of October, 26 women were in this way taken into Guy's Hospital for immediate treatment. On the other hand, the "District" is of great service as a field in which Guy's Nurses can obtain the necessary experience and training to enable them to sit for the examination of The Central Midwives' Board, and many who have not had time during their three years' training to explore on the other side of Borough High Street, learn what it is like to live "round about a pound a week," an experience that should be of great value to them in after social work. An ideal of the future is to combine the District experience with Midwifery instruction in larger Lying-in Wards in the Hospital than we now possess.

The "Nurses' Side" of Guy's Maternity Charity was, we believe, originated in 1890 by the late Dr. Horrocks, the well-known Guy's Obstetric Physician, requesting the Lady Superintendent of the Trained Nurses' Institution for some nursing assistance with local Midwifery patients. There were then only 47 Trained Nurses upon the Staff of the Institution, which Institution had been opened during September, 1884. Two nurses were set apart for this work, and from that, our Nurses' Midwifery Training School has grown.

We feel sure that all readers of this report cannot fail to have noticed, in the daily and weekly press, the prominence given to the now vital question of saving the life of the child, so necessary to the continuity of our nationality. If we are helpless before the destruction and mutilation of adult life in War, we can at least endeavour to realise our responsibilities for the 100,000 babies dead under one year—deaths caused by the ill-health and ignorance of the mother, or lack of decent habitation or adequate light, air, and food for the child. At this special and awful period of our history our "Maternity Charity" can claim to be of really national importance, and justify its existence even more than in pre-war times. A book has lately been published, "Maternity: One Hundred and Sixty Letters from Working Women," collected by the Women's Co-Operative Guild (George Bell & Sons, 2s. net), and we only wish it were possible to send a copy to each one of our subscribers. These simple statements of *daily* and *hourly* suffering endured, the torture of mind and body, which maternity brings to Mothers in ignorance and poverty, are a cry

for help to all those more fortunately situated. Every-one of these letters might have been written from the houses our nurses visit, and from their own observation the nurses can vouch for their truth. "Homes" of one, two, or three rooms, the water supply a tap in the street, and a rent out of all proportion to the wage; roofs, windows, and doorways that let in the rain, broken and dangerous staircases and banisters, within ten minutes' walk of Westminster and London Bridges. Apart from the nursing and midwife's assistance, it can easily be seen that our nurses can be of great help to these poor mothers. The influence does not end with the ten days' visiting; as our nurses are constantly in the same streets and buildings, they keep in touch with the women, and "old" babies are often brought along for inspection and approbation. An educated nurse who gains the confidence of these women can do immense good as there is an almost unbelievable amount of superstitious ignorance current in poor districts regarding the health and treatment of an expectant mother and her babe. So many little lives struggle into existence only to disappear, and a sympathetic neighbour makes the statement, "It's like as if it were to be so!"—which is certainly true, under existing conditions.

I should wish to add a short account of our expenditure to the end of October, 1915:—

We started our financial year January, 1915, with £144 2s. 6d. at the Bank. £60 has been spent by the Resident Midwife and pupils for immediate necessities for the patients they were actually visiting—rather more than £5 per month. These items include milk, coal, food, and nursing requisites, and an important item—gas. All the rooms in the Buildings have penny-in-the-slot meters, and as most of the confinements take place at night, the nurses are always careful to take a supply of pennies.

A number of our patients may have benefited by the higher wages, separation allowances, and the Maternity Insurance of 30s., but it must also be remembered that the rise in the price of food and coal affects the purchase of very small quantities to a far greater extent than it does with dealings on a larger scale. This state of things is now affecting our patients very seriously. It is no doubt improvident to send out just before a meal for penny-worths of tea and sugar, and to get in coal by the bucket, but most of the places are without a cupboard, and the Swiss Milk tin (labelled "Skimmed") and the remains of a saucer of cheap jam, when cleared off the table, find a convenient larder in one of the small top drawers of the chest of drawers. £42 19s. 3d. were spent upon Convalescent Home fees and travelling expenses, and medical comforts, including £20 given towards the support of a Queen's Nurse on the Externs' Side, whose work is referred to below. We have £41 3s. 3d. in hand for our Christmas dinner expenses, and to carry us along until our annual subscriptions are sent in.

In the area known as the Externs' Side the confinements are attended by the Hospital Students, known as Externs, under the direction of the "Charity." A "Gamp" is always in attendance, and "does" for the Mother and child after the actual confinements. For some time the want of a trained nurse to carry out medical treatment was apparent, and in 1913 such a nurse was appointed. The following report of Nurse Pitman's work will show how valuable it is. She is a Queen's Nurse, fully trained, and with a Midwifery Certificate, and resides at the Home of the Queen's Nurses in Bermondsey, which is in telephonic communication with Guy's Hospital. She does not attend at the time of the confinement, but visits for nursing purposes any patients referred to her by the "Charity," to whom she is responsible for carrying out all medical treatment. A record of her work is kept at the Out-Patients' Visitors' Office, and in consultation with Miss Beardoe-Grundy, when time allows, Nurse Pitman visits Mothers who require advice and help, especially with a first child, and when it is thought to be needed, encourages the mothers to either take their babies to Hospital, or apply for treatment themselves.

From October 1st, 1914, to September 30th, 1915, 502 cases were referred to Nurse Pitman, and 2,465 visits were paid. In only two cases was the treatment refused which had been advised by the "Charity." One woman, who was extremely ill and required much treatment, sent a thank-offering to the Samaritan Fund in recognition of the kindness, care, and attention she had received from Nurse and Mr. Stallman, the "Charity" at that time. In fact, small sums are often sent to the Samaritan Fund by grateful patients.

The Guy's Hospital Trained Nurses' Institution has undertaken to support the Nurse on the Externs' Side, and this year towards the £90 required, has received the before-mentioned £20 from the Maternity Samaritan Fund.

A certain sum of money is necessary to enable us to carry on our Maternity Charity, and we are also very grateful for parcels of old linen, old clothes of any kind, rugs and blankets. New baby clothes and new underclothing for mothers are very useful and a great delight, and are only given with discrimination to special patients. We trust that our friends, old and new, will not fail us in these difficult times. Please accept our thanks for all parcels, donations, and subscriptions, and we shall look forward with confidence to the assistance that will help us continue the work during the coming year, work that I hope I have not failed to show to be now more important than ever.

I shall be glad to send a report to anyone interested, with Balance Sheet and List of Subscribers.—Believe me, yours faithfully,

F. A. SHELDON,
Lady Superintendent.

10, St. Thomas's Street,
London, S.E.
November, 1915.

NURSES' SIDE.

VISITS PAID AND NUMBER OF PATIENTS ATTENDED DURING THE YEARS

1913.

Month.	New Patients.	Daily Visits.
January ...	83	939
February ...	74	764
March... ...	81	826
April	68	696
May	62	611
June	66	636
July	84	789
August ...	87	871
September ...	108	961
October ...	74	793
November ...	73	776
December ...	72	744
TOTALS ...	932	9,406

1914.

Month.	New Patients.	Daily Visits.
January ...	67	736
February ...	80	1,120
March ...	107	1,153
April ...	94	1,055
May	76	938
June	81	943
July	71	903
August ...	107	1,311
September ...	101	1,281
October ...	95	1,191
November ...	92	1,075
December ...	108	1,353
	1,079	13,059

1915.

Month.	New Patients.	Daily Visits.
January ...	91	1,295
February ...	86	1,063
March ...	115	1,352
April ...	112	1,322
May	85	1,208
June	73	984
July	83	842
August ...	103	1,078
September ...	94	1,125
October ...	64	1,074
November ...	—	—
December ...	—	—
	—	—

SIR,—I wish through you to speak to those who have been good friends to me for the past five years—the Students not in the Wards. On the rare occasions when I come up to the Hospital there seem to me to be far too many of these Students about; further, certain arguments with regard to their enlistment have been put forward in your paper as well as in the lay press which seem to me to be wrong. Whether this is so or not, time alone can prove; but that there is another side to the question is undoubted, and as it is possible that this side has not been put before the men concerned I should like to try and do so as clearly as I can.

My standpoint is this, that it is the bounden duty of every man, physically fit, who has not yet passed an examination which qualifies him to enter the Wards, and who is not up for such an examination next month, to leave the Hospital and join the colours—not wait to be called up in any class, nor to try and back out of it by becoming starred, but to go at once.

This proposition must be considered from three standpoints in the order of their importance—the national, that of the Hospital and School, and the personal.

We are constantly being told that these Students should remain at their studies because of the urgent need of medical men. This is a statement which needs analysing in order to see how these Students can affect the supply of medical men. This urgent need may be immediate and may be remote or after the War. The immediate need again may be for civilian work, and may be for military, but in either case the retention at their studies of men who can be of no such use for three years cannot remove this immediate need.

That there is immediate need for medical men for military work I am in a position to testify, that there is any shortage among the civilian population I am very doubtful. In the past year I have been stationed in four different towns in each of which the supply of doctors was practically undiminished, and in each of which the civilian population could well do with fewer. Organisation among the civilian medical men will very likely relieve the need among the military, and for the rest it must be made up from students in their fourth and fifth year

I do not and never have advocated that students in these later years should do anything but stay and qualify. For the first month of the war much of my time was spent arguing with men and urging them to this course, in one case as far as the inner recesses of the War Office where the student was applying to become a motor cyclist. I believe that at that early period I did as much as any of my colleagues to keep the senior students together and to prevent them rushing madly to the war.

But the case of the junior student is different, for he can only be urgently needed if there is a remote shortage of medical men either after the war or if the war be prolonged for a period of many years. That there will be a shortage after the war has been stated, but this is only an affirmation without evidence to support it. It seems to me that the exact contrary is likely to occur, and that the labour market in the medical world will be flooded at that time. During the past year many men have taken commissions in the R.A.M.C., who in peace time would have spent another eighteen months or two years doing house appointments and studying for higher examinations; further, many men have qualified three or six months earlier than they normally would have done. At the end of the war these men will nearly all

return to civil practice, but it is very unlikely that more than a small percentage will settle down to read for higher examinations instead of wanting to earn their own livings.

As to whether the junior students should stay at their studies in order to fill a shortage of medical men in the event of the war being protracted over a long period the Government and the Government only can decide, and the Government have stated most distinctly that they should not do so. The plain man would have thought the statement of Lord Kitchener some nine months ago to the effect that these students should not be dissuaded from joining the Forces to be clear enough indication as to what their duty was It was not so, for a deputation was sent to Lord Derby asking for his ruling on the matter. Lord Derby most clearly laid down that it was their duty to enlist. He was approached again with, I understand, a similar result; and yet attempts are still being made to persuade the authorities to give some other ruling than that which they have already given. From the national standpoint, then, the duty of these men has been laid down clearly and repeatedly by those who alone are qualified to decide.

Is there any reason from the point of the Hospital or Medical School why individuals should put these Institutions before the need of the Country as a whole? Again, one would have thought that the answer was clear, that in a crisis such as this the national need must come first even though it means the extinction of these two Institutions. And yet it seems from recent articles in the Press that this must be argued all over again. It has been put forward that a regular supply of students is needed to carry on the work of a hospital such as ours, and that this work must go on. I will admit that such a supply is needed for this work to go on as usual, and that the work should go on if it possibly can do. But that it is necessary for the work to go on as usual is not a fact, it may very well be carried on in an unusual way during the period of the war, to return to its usual course when the war is finished.

In August of last year the cry was started of "business as usual," and at the time it was a very valuable cry. At that time a thunder cloud of war had burst upon us with a suddenness totally unexpected. There was a danger of everyone being swept so far out of the normal course of his life as to be a danger to the public weal, and the cry of "business as usual" steadied many people and set them to face the crisis by going about their proper business. But now that we have been at War for seventeen months this idea is as pernicious as it was then useful, the conditions are so altered from what they were two years ago that any institution which continues as usual is either a negligable quantity or is not doing its duty to the state. When the supply of fourth and fifth year students is used up another class must be found to do the work in their stead. There is little or nothing at present done by Students that cannot be done by Nurses, and there are many women anxious to do something during the War who would willingly become Nurses, and who would not want to continue as such afterwards. Some people may be aghast at the idea of our Ward and Out-patient work being all done by women, but they must remember that there are more Hospitals without Medical Schools attached than there are with, that in these the work done with us by Students is done by Nurses, and done most efficiently. So also in the case of house officers, I would not advocate in normal times the admission of lady doctors to these offices, but I would sooner see them there during the War than feel that the Students of my Hospital had hung back at this time. Further, there are many elderly practitioners wishing to do war work and groaning because they cannot be accepted for the Army, who would probably be willing to come back as House Officers during the War; they might be out of date in their technique, and they might not make ideal house officers, but they would enable the business to be carried on though not as usual.

So also with the School. If all the eligible students went it might mean the shutting up of the School buildings for the rest of the war. This would mean a great strain upon the finances of the School; it might mean our either accepting a grant from the Board of Education or the Staff putting their hands into their pockets to make up the deficit. We have rather prided ourselves on our freedom from State control, but I would sooner see this principle go temporarily or permanently by the board, or pay my share in due proportion, than I would see the Germans in our midst or face an inconclusive peace. The very shutting of the School would have its advantage; it would let a few more of the younger teachers go than have already done. The lecturers on physiology and pathology might take charge of wards and so free two more of the assistant physicians.

From the personal point of view, I would ask you younger students whether you really feel satisfied at the bottom of your hearts that you are doing the right thing by staying. It is no longer a case of "doing your bit"; it is a case of "doing your damnablest." Are you persuaded by your parents to stay? Your parents will be the prouder of you when you have gone. Far be it from me to sow dissension between mother and son, but there are times when it is a boy's duty to disobey his parents, and if they now bid him to stay this is one. I believe that when you grow old you will curse the people who urged you to refrain from taking your share in the history of the world. I believe that before you grow old you will be looked down upon by those fellow students who will join the hospital on their return from the war, fellow students who will be your juniors in their medical career, but your seniors in courage, in determination, in decision, and in everything that makes the great doctor. It has been argued that the number of recruits to be got by all these students enlisting is so small that it can make no appreciable difference to the forces of the Crown, but this is a time when a single man makes a difference. The medical profession should lead, not follow. A hundred other

trades, professions and occupations want to keep back their young men, and look upon themselves as necessary to the community as we do. If the medical profession keeps back its students, the Guild of Haberdashers will wish to keep back its apprentices in order that the supply of underlinen and ties to the nation may go on. It has been argued that for a student to break into the middle of his curriculum is too great a sacrifice for him to face; but it is a small sacrifice with life before him compared with those which older men have made by the thousand. If the enemy were landed on our shores is there one of you who would hesitate?

We are faced with an eventuality even more terrible than this, an inconclusive peace, for an inconclusive peace means that all this must be fought again by our children and our children's children. It is such as you that have it in your power to decide whether there shall be an inconclusive peace or not. Those who have laid down their lives "over there" have done so gladly, with the thought that the children they have left behind them will not have to go through what they have, and we who have changed every aspect of our lives are looking forward to following them over; but they did not lay down their lives and we have not become wanderers upon the face of the earth to arrive at such a state that things are left as they were before, and that all must be done over again in twenty, thirty, or forty years' time.—I am, dear Sir, yours faithfully,

T. B. LAYTON,
Christmas Day, 1915 Major, R.A.M.C. (T).

DEAR ———,—I am so glad I came here, everything is so amusing and queer. This is a French workhouse, and we live in such a primitive way; it might be trying, only I have a very nice bedroom with a stove and a writing table. There is a most delightful doctor who spends half her time here and half—alternate days—at other places about 50 miles away. The "Mission des Amis" has 25 motors all told, the doctor has one and there is a big Napier, and there is a Secretary who has an ambulance, so we don't do badly. We fetch and return patients from all sorts of interesting places, and I have had some most interesting times. On Wednesday I managed to fit in a visit to the Emergency (British) Hospital, which inhabits a château looted by the Crown Prince. There were trenches dug by the Germans when the French attacked and drove them out; and the grave of a friend of the Crown Prince is opposite the front door, besides many others. The trenches were very close to the house.

The roads are so interesting because of the soldiers one is always meeting, and the villages, many in ruins, make one feel as though it was a Stanley Weyman novel instead of real life. To-day was even more interesting—we passed under fire for several miles, the second line trenches, emplacements for guns, barbed-wire entanglements were all close to, and each side of the road. Mr. Fryer, a sort of half Frenchman chauffeur, said the troops never went that way because it was too dangerous. We saw the German trenches quite easily.

When we got to Rheims we found we had come in for some German hate, and shells were bursting quite unpleasantly near. The people of Rheims had departed to their cellars and not a soul was to be seen. Mr. Fryer decided to look up some children in the suburbs and then we went and had lunch. Meanwhile the whiz-bang kept on at intervals of four minutes. We had finished lunch, and Mr. Fryer said he had some more children to collect, and suggested that I should do some sight-seeing and meet him two hours later at the hospital. He told me to keep the German side of the road and to lie down if I saw a shell coming. It was awfully muddy, and I asked how I was to know, because I should feel rather a fool if I lay down and the shell went off in the next street; but he said I must risk that. So I went off to see the Cathedral. Everywhere were wrecked houses, some of them evidently quite recent, and not a soul anywhere. The Cathedral was ghastly, but beautiful, like a corpse of a beautiful woman, and Jeanne d'Arc astride her horse untouched amidst the wreckage, and always the whiz-bang of exploding shells every four minutes. It was beginning to pall rather, when I caught sight of a woman in a doorway and asked her if she would show me her cellar. She was quite pleased, and, lighting a candle, took me down and showed me regular catacombs full of furniture and household goods. Where she slept was absolutely safe, she told me, but it was a long way underground and awfully damp. Her husband had been wounded in an upper room and she nursed him till he died there, quite alone. I asked her why she didn't go away, and she said she had the keys and so many people had left things with her, she must look after them. Then I went and found a shop in an arcade where I bought post cards and wrote them. I then found another shop (under ground) and bought crockery, and still the bombardment continued. I asked the way to the hospital, and was told that it was impossible to go that way because all the shells were falling there. I wondered what to do, because I must be there by 3 o'clock to meet Mr. Fryer. I decided "to keep the German side of the road and look out for shells." As I walked along I found the streets becoming less empty, and came to the conclusion that the hate must be over—and it was. In a few moments the streets had become alive with women coming out to do a belated shopping.

I got to the hospital and had a most interesting time seeing over it. The matron was trained at the London Hospital, and is most charming. Mr. Fryer told me that she has saved her life several times by lying down when shells come. They have a ward underground, and the nurses sleep in the cellars

There are 600 beds, but only 90 patients now. She has to keep her staff ready, but it is hard to keep them employed. They were white enamelling everything when I was there. There was a charming children's ward with a few little patients—and flowers everywhere in spite of broken windows and debris. I came to the conclusion that she was a most brave woman. Five patients and a nurse have been killed and nine shells have fallen on the nurses' bedrooms. She said the Germans were quite polite to her when they were in occupation. The building is a beautiful old monastery and has been hit 27 times.

I must stop now, though there is lots more to tell. I give anæsthetics here and do all the dispensing, and take the babies to be christened (a most elaborate ceremony), and have to write French letters to intending patients; so life is varied and amusing. Then there is occasional night work when a patient arrives on the doorstep in urgent need of medical attention and the doctor is fifty miles away. We eat off American cloth, and one spoon has to serve all purposes, but I generally manage to get another one, because I am "*Directrice*," even in this democratic community.

Maternité Départementale,
Chalons-sur-Marne.
December 4th, 1915.

Ward Concerts.

ESTHER.

On Monday, December 27th, Sister Esther invited one friend of each patient to tea, as she did last year; an excellent tea was provided which they all seemed to enjoy very much. After tea an informal concert was held, which Nurse Shepherd opened with Offenbach's "Barcarole." Miss Messenger's dancing was charming and was greatly appreciated, and she got a well merited encore. Nurse Smith then gave two very excellent violin solos. Princess Iwa sang two songs, one a Maori one "Waiaitopoi," which she rendered charmingly.

The concert proved a great success and was highly appreciated by the patients, and the best thanks of the ward are due to the ladies and gentlemen who so kindly helped to entertain them.

The following ladies and gentlemen sang:—Miss Carter, Miss Fisher, Miss Boutell, Miss Cowan, the Misses Figgs, Nurse Gibson Sugars, Nurse Shepherd, Nurse Figg, Nurse Bailey (recitations), Mr. Knott, and Mr. Galbraith.

MARY.

On Monday, December 27th, a concert was held in Mary Ward. The concert began at 4 o'clock, and before this the patients had their friends to tea. Miss Young set the ball rolling with a delightful piece at the piano. Miss Drysdale gave some fine recitations. Miss Bryant sang several songs, all of which were appreciated greatly. Miss Attwater played upon the violin with some skill, and the patients and others enjoyed her thoroughly. We were fortunate in securing the services of Mr. Charles Cory, who gave some humorous sketches at the piano. Mr. Hirsch gave his well-known sketch, "Cohen on the Telephone." Mr. Galbraith and Mr. Attwater also sang. The programme was concluded with a performance by the Guy's Hospital Septette, led by Mr. Curle. They were very much enjoyed.

EVELYN.

Evelyn "Concert," which scarcely deserves the name, being merely a "sing-song," took place on Monday, December 27th, at 3.30 p.m. There were no invited visitors but the patients' friends, but a goodly number joined us during the afternoon and evening, and the result was an appreciative audience, who applauded and sang the choruses with a spirit worthy of recruits. Our thanks are due to Miss Fuller, Miss Boutall, Mr. Goldeney, Mr. Watson, and others, whose singing was much appreciated, and who kept us well entertained until the arrival of the "Nuts." The Sextette was greeted with enthusiastic cheers, and gave us of their best, so that it was nearly 8 o'clock when Mr. Kendall finally brought the concert to a happy close with "I love the Ladies" (by request).

PATIENCE AND SAMARITAN.

The Patience and Samaritan Concert was held on Monday, December 27th, at 3.30. Though on a smaller scale than some others, it was well attended and very merry. Miss Venables' and Miss Carter's songs were in great request, Miss Venables' rendering of "Down Vauxhall way in the morning" being especially appreciated. Miss Verdon's recitations were frequently encored, and Mr. Verdon's comic turns kept everyone amused, yells of laughter from the pitful of children greeting his grimaces. George, a young visitor from Astley Cooper, gave a few comic turns on his own, for several times when the performers appeared to be getting excited he went up to them and held their hands, apparently trying to soothe them.

After the tea interval Miss Messenger gave a very beautiful dance, which was heartily encored. Nurse Gibson Sugars sang "My little Grey Home in the West," and consequently had to sing several times again. The anxiously awaited arrival of the Sextet from the "Niggers" was greeted with a roar of applause. Their programme was necessarily limited owing to the heavy demands made upon them by concerts in other wards. "Where are you going to, my pretty Pro?" by the Sextet, and "I'm in love," by Mr. Wilson, delighted the audience. The volume of the choruses and the applause showed how heartily everyone enjoyed all their items. The topical verses of "Archib-b-b-bald" were greatly appreciated by all alike and this brought the concert to a close.

CHARITY.

The concert in Charity took place on Tuesday, December 28th. The programme was arranged by Miss Irene Vanbrugh, who was unable to be there by reason of a previous engagement. Her place was taken by Miss Nina Sevining. The programme opened with a pianoforte solo, while songs and recitations followed. Miss Helen Mar amused us with some funny little stories and anecdotes, and two violoncello solos were very much appreciated. Smee, in his original costume in Peter Pan, amused us very much with some of his Irish stories. The proceedings ended with a "flying mystery" who presented signed post card photos of Miss Irene Vanbrugh and Father Christmas who presented the toys to the children. A vote of thanks was then passed thanking the artistes for their excellent programme, and "God save the King" brought a very delightful afternoon to a close.

ADDISON.

On Tuesday, December 28th, a very excellent concert was held in Addison Ward, beginning at 3 p.m. There was a large and appreciative audience. Madame Gilbert Russell sang first, and she was accompanied at the piano by her little daughter, Marie Doris, who played in a really wonderful way. Miss E. Wilinski then recited very amusingly about "Mice." Mr. Godfrey Tearle very kindly entertained us; he was much appreciated by all. Miss Attwater played the violin. There were songs by Mrs. McGregor, Miss Drysdale, and Miss Wilinski, all of whom were much enjoyed, and Mr. G. L. Attwater, whose "Kaiser Bill" went down well. There was an interval for tea. After tea, Madame Gilbert Russell again sang, followed by Mr. Knott, of nigger fame. All those who took part in the first part of the programme (including "Parson Att") again contributed to the second part. A patient (No. 20) also sang for us, and was much enjoyed. Soon after 5.30 the famous Septette arrived, and gave us a full and enjoyable programme; their sparkling wit and bubbling humour thrilled us all. The concert ended just before 7 p.m., and was declared by all to be an immense success. Many patients from other wards were present.

NAAMAN.

The Naaman Concert was held on Wednesday, December 29th, at 4 o'clock. This was, unfortunately, the day the "Niggers" were visiting Southend, so there was practically no local talent available. However, Sister Naaman had collected a veritable army of dancers and singers and performers on the piano and violin. Proceedings were opened with tea, followed by a "bran-tub" for the children, and another for adults, after which the concert proper began. Mr. Alfred Beck's party began. Miss de Escobar and Miss Pearcey sang, Miss Russell played the violin, Miss Robertson gave a Highland dance, and Miss Cox and Mr. Beck recited. All these performances were extremely good and heartily applauded, but a late start had been necessary and the programme was a full one, so very few encores could be given.

After this a short play entitled "The Rest Cure" was given by Miss Oldendorff's party. This was very funny and very well rendered, and the troubles of the unfortunate patient caused great amusement. The way his sleep was disturbed seemed particularly to please the patients in the audience, who were tickled, no doubt, at the contrast between it and the nocturnal quiet of their own ward. Before and after the play The Rest Cure Orchestra played selections, and afterwards Miss Oldendorff danced a hornpipe which was enthusiastically encored. Mr. Davis gave a very good musical recitation and a song. Miss de Escobar sang again. Mr. Beck gave a very humorous recitation about a drive in a motor car, and Miss Pearcey wound up the evening with a song in which all joined vociferously in the chorus. It was a great pity there was not time for more encores, for the performances were unusually good. After the National Anthem had been sung, three very hearty cheers were given for the performers and three more for Sister Naaman. Her untiring energy in preparing and organising reaped its own reward in the success of the concert which, from beginning to end went with a swing, enjoyed equally by patients and visitors.

CLINICAL.

This concert was held on Thursday, December 30th. Sister Clinical provided an excellent tea, which was thoroughly appreciated by all. We all were very disappointed that Mr. Godfrey Tearle and his party from the Adelphi could not come, but they were unavoidably prevented from coming.

This concert was held in John and Miriam simultaneously, as the nature of the building does not allow of the beds being moved from one ward to the other.

Mr. Fred Wright, from the Adelphi, started the concert in both wards with a few short stories, which were highly amusing and much appreciated. Little Miss Mary White's dancing was very graceful and gained much applause. Nurses Cheveau, Gibson, Sugars, Jordan and Shepherd all sang with great success, and were highly appreciated. The Misses Greens' playing and singing was most enjoyable, and helped much to the success of the afternoon.

"Count Blotto" and his party, from Southend, proved a great attraction in Miriam, and the audience gave them a hearty reception. Unfortunately they were unable to give a performance in John, as time would not allow of it. Nurse Haynes concluded the concert in John with a violin solo, and gained a well merited encore.

The concert proved a great success, and the best thanks of the ward are due to those ladies and gentlemen, both inside and outside the hospital, who so kindly came and helped us. Special mention must be made of Miss Gray, who kindly acted as accompanist throughout. The following gentlemen also sang:—Messrs Attwater, Galbraith, Knott and Hirsch ("On the Telephone.").

MARTHA.

The true spirit of Christmas found vent in Martha in the form of a concert, and, as in most concerts, there were three factors which played a prominent part. The first, which is essential to any properly-conducted entertainment, was the decoration scheme. Now, in view of the rumour at present circulating that colectomy is the certain cure for pessimism, a rather severe theme was worked out in order to prevent the casual observer from thinking that things are always as they seem. The most artistic effort was the clock, which had long since given up the struggle for respectability, and, clad in a rakish attire, pursued an uneven course of unreliability. The second factor which comes next in importance was the audience, whose appreciation was truly good in quantity and quality as shown by the applause, but the most satisfactory feature was that all the chairs so arduously hauled from their normal habitats far and near were filled to overflowing, and some, it is reported, supported more than their usual amount of human cargo. Lastly, the third factor was the performance. The Sextette, of course, performed, an item which was looked forward to and for which the memory hankers. Vocal solos were rendered with effect by Miss Carter and Miss Willie. At the piano Miss Bristow produced sweet melodies, and Nurse Slade recited to the intense delight of the audience. Mr. Ireson Woods was able to make us believe that there really was a man in the cellar who had a grievance against a man on the roof, and after a display of dexterity with some subtly folded paper, proceeded to play tricks with handkerchiefs and other pseudo commonplace articles. The theme of the whole concert was punctuality! Even the Sextette appeared within half an hour of its scheduled time, and tea did not occupy more than fifty-three minutes.

LAZARUS.

The casual visitor who sought to choose among the various attractions adverrised by the multicoloured posters in the Colonnade was indeed fortunate if chance or design led his steps to Lazarus—for there they saw a dainty galaxy of wit and beauty—sights to charm the eye and ear. The scheme of decoration designed, we are informed, by Sister, and nobly helped by Messrs. Debenham and Caldecott, was composed of Ivy, their lacquered leaves blending harmoniously with the delicate pink of the lamps, whilst the flags of our brave allies ran the gamut of chromatic contrast. Nor was the vocal and instrumental part of the proceedings less enjoyable. Besides the famous Sextette and the Obadiah duet. whose achievements are no doubt amply, but even then insufficiently recorded elsewhere. Miss Hallward's able Company gave the amusing playlet "A Case for Eviction," which was greatly appreciated by everyone. Some really fine virtuoso playing by Mr. Rohan Clamey, of the Globe Theatre—a fast hit this!—and some dainty work by Miss Hodges. Mr. Barclay Morris gave some semi-comic character studies, and last, but not least, the Conjuror, one "Ramjee," by name, whose mystifications delighted the juvenile section of the audience. The proceedings closed fittingly with the National Anthem.

LANDON OUT-PATIENT TEA.

Once again we have to record the Annual Landon Tea Party, given in Out-Patients, to seven hundred of the boys and girls of the Borough. The large Out-Patients' Hall rang with the shouts and laughter of these children on Christmas Day. The girls, looking so clean in their white muslin pinafores, soon got busy on the eatables, the little boys literally "stuffed" themselves inside and out, pockets and Jerseys alike bulging with buns and apples. Then the Niggers appeared at one end of the hall; it is impossible to describe the wild excitement, the roar of seven hundred children all shouting and singing; while the boys made a combined attack with apple cores and pieces of cake, and many a good shot there was, too.

Some sort of order having been obtained, the Niggers started to sing a few popular songs, instantly taken up by their wondrous audience; the piano, big drum, little drum, and even the flute were drowned in the roar of voices. The remainder of this merry afternoon was taken up by a concert arranged by the Ward Maids, which provided great amusement; the costumes and the singing were excellent. The party closed with each child receiving a parcel containing clothing, sweets, fruit, etc., and a toy from the Christmas tree presented by a real Father Christmas.

We thank all friends for their very generous help, and especially do we wish to offer our congratulations to Sister Out-Patients for all the time and trouble she has spent in bringing so much joy and happiness into the lives of our Borough children.

Rugby Football.

GUY'S v. ROYAL NAVAL DIVISION, CRYSTAL PALACE.

For this match at the Palace on December 11th we had to make many changes, and then found that so many backs were available that only by playing five three-quarters could they all be got into the side. Our opponents as well had difficulty in completing their side, players chosen having gone on leave and their absence not apparent until almost playing time. The referee originally chosen not turning up, Lieut.-Commander Hendry took charge of the whistle, and had the pleasant duty of controlling a good and well contested game.

The venue of the match was the famous Palace Association ground, but how different the surroundings from those in time of peace. The huge stands were now partially filled with young Tars undergoing training. Some officers were in the centre stand, but no general public, the members of which are not allowed within the Palace precincts. The ground was very heavy, and the ball resembled very soon nothing so much as a piece of wet soap, but for all that Guy's handled it splendidly, and Curle quite early in the game ran through the opposition for a good try which Medlock easily added to. A further try from Blacklaws was soon forthcoming from the same tactics, most of the Guy's three-quarters handling with accuracy while going at full speed. The angle was too acute for conversion. One try was scored against us this half; Thomas not clearing in time was overrun by the quick following up of the Sailors, Llewellyn scoring.

From now to the end we had to play one short, Blacklaws going off lame. This second half did not see our men to so much advantage; they got the ball less often. A goal accrued to either side; ours came first, the result of plucky and persistent following up on Micklem's part, who bustled Manby, with the result that Reitz, who was well up, secured and touched down for Medlock to goal. The Sailors got their goal after much hard work; on several occasions they were almost in, but luck was against them, until Leading Seaman Powell got a well-deserved try for Speckman to goal amid the enthusiasm of the very impartial naval audience. Final score—Guy's (2 goals 1 try) 13 points; R.N.D. (1 goal 1 try) 8 points. Team:—

GUY'S.—G. M. Thomas (back); G. W. Allen, F. J. Harrington, C. L. Curle, E. A. Leviseur, G. L. Blacklaws (three-quarters); C. H. Medlock, C. B. Micklem (halves); G. F. Kidman, A. W. A. Davies, A. W. Reitz, J. G. Gie, E. W. Hawes, E. A. Phillips, J. C. Curzon (forwards).

Marriage.

MESSENGER—WOOD.—On December 22nd, 1915, at the Church of St. Mary the Virgin, Yatton, by the Rev. M. R. Green, assisted by the Rev. Dr. C. E. Browne, Henry Leslie Messenger, L.R.C.P., M.R.C.S., L.D.S., of 47, Rosslyn Hill, Hampstead, eldest son of Mr. and Mrs. H. W. Messenger, of Roundstone, Augmering, Sussex, to Lily, younger daughter of Mr. and Mrs. J. G. Wood, of Westfield, Yatton, Somerset.

Death.

CHILDE.—On the 14th December, at his brother's residence, Cranleigh, Kent Road, Southsea, Lt.-Col. Letterstedt Frederick Childe, I.M.S., M.S., M.B. Lond., M.R.C.S., of Roundhay, Banbury Road, Oxford, late Senior Officer, St. J. J. Hospital, and Prof. of Medicine, Grant Medical College, Bombay.

E. N. G.

GUY'S HOSPITAL GAZETTE.

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Passim.

AT our first appearance in the New Year it is our sincerest hope that good fortune and bettered conditions may he the lot of all and sundry—and more particularly of our friends and readers abroad and at home.

The past year has abounded with so much that is opposite; change and catastrophe, reform and success, moral triumphs and failure. that to-day we awake with a sense that the strongest side of our national character will rise above surrounding chaos, and that we may justly view the world situations with the eyes of true optimism.

Our Christmas festivities have been such that the memories of 1915 will give to us always one bright thought, for the closing hours of the year were far from dull at Guy's.

The concert in Astley Cooper Ward was an unqualified success, and all are indebted to the people who gave their services—visitors and colleagues alike. The Septette made a last appearance with their usual success, while the ward funds will bear witness to their resource in novelty and persuasion. We applaud both the buyer for his liberality and the auctioneer for his success.

A quaint note was struck when, in a land of inky darkness, Guy's welcomed the new year. Thanks to the efficiency of the hospital telephone system, which never gave a better proof of its powers to reach and control the uttermost corners of our buildings, every man asleep or awake, wandering or immured, bored or in ecstacy, was brought hurrying to the Colonnade. Headed by the dimmest of dim red lanterns, the procession made its way to the statue of old Guy, and in the darkness the President made his perilous ascent. The hour of midnight resounded in time-honoured fashion—only the dancing flames and heat of former years were lacking. Voices and drums—and then more voices, until they dwindled into harsh raspings, succeeded in making us forget how altered were the "visible" signs of welcome, and "Auld Lang Syne" was sung with as much fervour as in the days when the faces around the wide circle were not left so much to the imagination.

WE are glad to hear that although the Residents' Play is to be omitted this year, the two evenings' entertainment will be provided in an altered form, and on January 28th and 29th concerts will be given by the efforts of local talent and without professional assistance.

OUR sincerest sympathy goes out to Dr. Hale White in the sad loss of his son on H.M.S. *Natal*.

IT is only a short while ago that the Niggers were so well received and so kindly entertained at St. Mary's Hospital, Southend, and we are sure that Dr. Hale White's greetings and consideration made an ideal send-off for the troupe when they arrived by the sea on that most enjoyable day.

IT is good to hear of the improvement in the condition of Dr. Lauriston Shaw; we wish him all speed towards recovery.

AMONG the names of those temporarily leaving us appears that of Dr. H. W. Barber, medical registrar to the hospital. He has taken a commission in the R.A.M.C., and although, as we believe, remaining in England some short while, he leaves on foreign service in the near future. We wish him all good luck.

WE are asked to express thanks to the various firms which forwarded the pianos used during the Christmas festivities; the list appears in later pages of the GAZETTE.

WE would call attention to the fact that the Annual Subscription of 12s. 6d. to the Hospital Gazette and Reports is now due, and should be made payable to The Manager, Gazette Office, Guy's Hospital.

Papers by Guy's Men.

R. H. Jocelyn Swan, M.S., F.R.C.S.: Trench-foot, or so-called "frost-bite."—*The Practitioner*, January, 1916.

Arthur F. Hertz, M.D. Oxon., F.R.C.P. Lond., Major R.A.M.C. (in collaboration with Arthur W. Ormond, F.R.C.S. Eng., L.R.C.P. Lond., Capt. R.A.M.C. (T.)): The treatment of "concussion blindness."—*The Lancet*, January 1st, 1916.

R. G. Chase, M.B., B.C. Cantab.: Two abdominal cases.—*The Clinical Journal*, January 5th, 1916.

Montague F. Hopson, L.D.S., R.C.S. Eng, J. Lewin Payne, M.R.C.S., L.R.C.P., L.D.S., Frank J. Pearce, L.D.S., R.C.S. Eng., D.D.S. (in collaboration with Stanley P. Mummery, M.R.C.S., L.R.C.P., L.D.S.): Treatment of jaw fractures.—*Journal of the R.A.M.C.*, December, 1915.

Change of Address.

Capt. C. Sherris, R.A.M.C., No. 12, Field Ambulance, B.E.F.

E. Royston Saul, L.D S. Eng., from Eastbourne, to 17, Harrington Gardens, London, S.W.

University of London Officers' Training Corps.

Medical Unit.

Guy's Hospital,
January, 1916.

Dear Sir,

As some doubt seems to exist as to the position of the Medical Unit of the University of London O.T.C., it may be as well to give the following particulars:—

The unit is on a peace footing. Men join for two years in the first instance, or till they join the services. They have to render themselves efficient in each year under penalty of a fine of £2, unless they join the services within that year. For efficiency, attendance is required (except in the case of illness) at twenty drills and at summer camp, which lasts a fortnight. If necessary, attendance at summer camp can be cut down to a week, the required drills being made up in other ways. There is also a brief voluntary camp at Whitsun which counts for drills. The year ends on the 1st October. Uniforms are provided, the wearing of which is not compulsory except at camp.

Those eligible are: fourth and fifth year medical students and third year students, provided they pass the Second Conjoint examination or its equivalent by March next, also those medical students of the first three years who are not eligible for the army.

Under present conditions, the aim of the unit is to enable men who will probably join the R.A.M.C. on qualification before the end of the war, to learn drill, camp duties, and general organisation, and, if possible, to pass the A and B medical certificate examinations.

Surgeon-General Russell has issued a letter from the War Office pointing out that it is extremely desirable that men joining the R.A.M.C. should have acquired such preliminary knowledge.

As to the Guy's subsection, lectures will be given at Guy's this term, some of them by Major Gray, and drills will be held as soon as the condition of the Park permits. Times of drills can be arranged to suit the men in the wards. Any men intending to join should communicate with me as soon as possible.—Yours faithfully,

J. H. RYFFEL.

Massage Department.

Dear Sir,

It may interest your readers to learn to what extent the work of the Massage Department has increased since the School was opened to non-resident students in 1914. Both the number of new patients and the number of treatments has more than doubled, as the figures below will show. Many improvements have been made both in the Department and in the School. A large waiting-room to hold 100 patients has been erected, close to Clinical, communicating with the old massage rooms, and apparatus has been made on the premises to allow 20 students to work at one time. The old arrangement of schoolroom and gymnasium combined has been changed, and we now have a large gymnasium 80 ft. by 16 ft., a massage room 40 ft. by 16 ft., for the students to practise on each other, and three class-rooms, each to hold 24 students. We have now over 50 students training for the different examinations of the Incorporated Society of Trained Masseuses, which, owing to the great demand through the war, have been increased from twice yearly to every two months.

Since November, 1914, 32 students have entered for examination; 31 gained certificates in Anatomy, and 30 in Theory and Practical work.

The first course of Swedish Remedial Exercises has started, for which there are eight entries. This course affords facilities for a large increase in the treatment of medical cases, *e.g.*, heart disease, by appropriate exercises, and we shall be very glad to be provided with material from every class of disease in the Medical Wards or Out-Patient Department for which Swedish Remedial Gymnastics may be thought to be advisable.

There is still room for much research in this branch of the work, which is being conducted with the advice and under the supervision of Dr. Poulton.

The statistics for the last two years are as under:—

	1915.	1914.
NEW PATIENTS—		
Wards...	385	157
Out-Patient Department ...	1,112	540
Total ...	1,497	697
TREATMENTS—		
Wards...	5,471	together
Out-Patient Department ...	19,751	8,862
Total ...	25,222	8,862

—I am, dear Sir, yours truly,

H. S. ANGOVE,
Sister in Charge.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

H.-Q., 54th Division,
Med. Ex. Force,
Gallipoli Peninsula.

DEAR SIR,—"Forsan et hunc olim meminisse juvabit." I shall be glad if you will add my name to the list of Guy's men on active service. Apologies are due from an old editor and war-correspondent of the GAZETTE for not having given you notice or written to you before; but writing under present conditions is far from attractive and writing for publication presents many difficulties.

We are serving here under conditions a good deal more primitive than in France or even in Serbia, for the only trace of a building within miles is the wreck of a one-roomed farm-house. We dig-in wherever we can, and otherwise have only ground sheets for protection against rains and gales, which are already fierce enough although still quite mild. So a page or two of our experiences may be of interest, although no scientific or complete statement of the physical condition of troops is permissible under Field Service Regulations.

This Division disembarked in Suvla Bay in the week following the landing of Saturday, August 7, and took part in the subsequent advance inland. It was necessary to throw all the possible force into the firing line at the earliest possible moment. A bare minimum of supplies, ordnance, water, and mules for transport having, therefore, been landed, the tugs and lighters necessarily occupied themselves with the landing of troops with their bare equipment and iron ration. This is essential to an understanding of the medical conditions. These were fresh troops, straight out from a life of healthy training at home, territorials with no experience of war. From two to three weeks they had spent on the sea, cooped up on board ship where, with the best will and discipline in the world, athletic fitness could not be maintained. They were suddenly landed in almost tropical heat and thrown straight into action in a very sparsely cultivated country, and that a new line without trenches and with little cover. There were few local wells, giving little water and that of variable, mostly inferior, quality. The mules that brought food and water up were heavily shelled; the difficulties of distribution were great; the heat and strain severe; the casualties many. If in England, as is officially taught, a soldier loses a quart of water in marching seven and a half miles, what must have been his water needs under these conditions? And yet,

often he could not get even the *pint* of water allowed him at that time for *all* purposes in the twenty-four hours. Hunger, thirst, fatigue, strain, continued day and night—inevitable under the circumstances—were bound to tell on the troops. They would have told even on the hardened veterans of Helles and Anzac. It was a severe military baptism for territorials. The effect was a general weakening of bodily resistance to microscopic foes, which fight impartially against both sides in every campaign, and which it is the peculiar privilege, and most difficult task, of the medical service to resist.

It is generally forgotten by the public, it is often not realised by the personnel of the non-regular R.A.M.C.—as your own columns bear witness—that the treatment of wounds is a subsidiary function of a modern Army Medical Service. The first duty of the medical service, as officially laid down, is to prevent disease; the second, to evacuate the sick and wounded; the third, to treat those slightly sick and wounded so as to secure their early return to the front; the fourth, to give treatment and comfort to the individual for his own sake. It is with the fourth function that the Red Cross and public subscriptions and sympathies are mainly concerned. But it is on the first three functions that the efficiency of the army and the interests of the nation most vitally depend. These three functions are almost the sole concern of the medical services at the Front, that is, on this Peninsula, and the first is in the hands of the Regimental Medical Officer. A paragraph, then, on this supremely important being.

In the Suvla Bay fighting during the week after landing, the Regimental medical Officer, like the combatants, had to do what he could and how he could. Like them he was advancing in darkness under fire, through unknown, roadless, broken country, rock and scrub (thick bushes), hillocks and gullies, that afforded little cover and no opportunity of taking any long or broad views of his battalion or of his work. For some time he could not establish any regimental aid post; he crawled about, bandaging wounds with his stretcher-bearers, and helping himself to bring in the wounded, sometimes by day, mostly by night. The strain was intense, and four strong, healthy, mature R.M.O.'s out of the twelve in the Division succumbed to it in the first few days. One had dysenteric diarrhœa as his main symptom; one was suffering from exhaustion capped by a shell explosion within a few feet; the third, a jolly young giant, from a prosperous suburban practice, finally succumbed to the shock of being called on to attend four of his best pals, laid out by a single shell; the fourth had lost his brother, a combatant officer in the same regiment, in the action, and was brought down on a stretcher as if moribund; with the utmost pluck he pulled himself together in twenty-four hours, and set out again for the trenches, but fainted on the way up and was packed off on a hospital ship. If such was the strain on the medical officers, it may be imagined what its results were on the troops.

In a few days things began to improve; trenches gave some degree of shelter; the line was straightened out; definite regimental aid posts were established; hours and duties defined; communications ensured; supplies improved. Still the first thought of the R.M.O. had to be the immediate welfare of his men; and treatment of the sick as well as of wounded began to bulk largely in his work. Sanitary work could only be extended to the provision of latrines and urinals wherever and however possible. There was bound to be a general fouling of the ground. Ablution was impossible. Flies, barely existent at first, were breeding freely, but as yet not obviously. The questions of food and drinking water were necessarily confined to those of quantity and distribution. Except for the heat of the day, the weather was entirely propitious. The main health object was to secure some kind of rest for officers and men, consistent with safety.

The further prevailing difficulty of the R.M.O. at this stage lay in the inevitable changes of area. Units were constantly being shifted from one place to another in the firing line or brought back to the rear for a comparative rest. Danger by day and darkness by night made sanitary work impossible. The prevention of disease was, in fact, for the R.M.O. an impossibility. Anything that could be done lay in the hands of the company, and regimental officers, whose attention was r ivetted on their tactical duties. Absolute prevention of disease in acute warfare is, in fact, impracticable. In actual fighting, troops must depend for their health on luck, habit, and the supplies of nature, and the Army Service Corps.

Since the end of August, however, the R.M.O. has had his chance, although for actual prevention of disease the chance comes late. We have been settled into definite lines of trenches in a definite area, with a definite routine of duties: so long in the trenches, so long in the "rest" camp. Casualties play a minor part; ill-health and definite disease are to the fore. Now is the time for the R.M.O. to play his supreme part in war. Every morning at 7 or 8 he holds his sick parade, and on a hillside facing the Aegean he dispenses drugs from his paniers, gives advice to some 50 slightly sick, and decides in each case whether they are likely to be mere passengers in the boat for more than a couple of days. If so, they go down to the field ambulance on the beach; if not he tinkers them up, encourages them, advises them, excuses them duty for 48 hours, and arranges a light diet for them.

Then come his general duties. Eight sanitary orderlies should be attending to the latrines, urinals, and slop-pits, collecting all rubbish and refuse about the camp and burning it on the incinerators. The kitchens and stores require constant inspection, the cooks constant vigilance. A N.C.O. and four water-duty

men of the R.A.M.C. attached to the unit should be at work on the water-cart, straining the water, pumping it through alum and bleaching powder; sterilising the cloths, cleaning out all parts and vessels employed, keeping the whole in constant repair. The 16 stretcher bearers should be properly distributed to report and give first aid to any casualties that may occur. The medical officer's corporal will be carrying out the details of treatment ordered at sick parade; his orderly will be attending to his kit or dug-out, washing his clothes, and taking messages for him. Company officers, too, have to be visited in connection with their own share of sanitary responsibility for their respective lines or as regards the health of their individual men. Men found breaking the sanitary regulations have to be brought up before orderly room.

The C.O., the Adjutant, the Quarter-master must be frequently consulted at such times and places as they may be found disengaged.

All this internal regimental work is vital to the health of the unit, and is made all the more difficult on account of the constant change of personnel, both officers and men, as the campaign takes effect in sickness and casualties. The regimental medical establishment suffers no less than the rest, and the R.M.O. has to work on an increasing task with diminished numbers and those indifferently, if at all, trained in their duties. He has, therefore, to be constantly giving them practical demonstrations in their work and bringing them promptly to book for their mistakes or neglect

It is in these particulars that the difference mainly lies between a good and an indifferent R.M.O. But it is these very things that are strange to medical men, fresh from civil life. Most of them can and do carry out efficiently the treatment of their slightly sick and of their casualties, most are eager to do heroic deeds in succour of the wounded; but medical students learn little public health at hospital, and subsequently in their home practise they leave such things more and more to sanitary authorities. On being put to regimental duty they find attention fixed on more urgent matters and, not wishing to make difficulty, are tempted to let these duties slide.

The work of the D.A.D.M.S. is of first interest, as it gives a complete view of the medical work—and incidentally of all the work of a Division. As deputy to his chief he is second in command of the R.A.M.C. of the Division, and acts on his chief's behalf in his absence from camp or in case of his sickness. He is thus brought in touch with the work of the three field ambulances, with the clearing stations, with the other departments of his headquarters, with the higher authorities of the corps and of general headquarters. He personally visits the regimental M.O.'s and their units and the advanced dressing stations of the field ambulances. As medical officer to the headquarters' unit he is himself responsible for the health of an important body of men, in this case numbering, with attached details, some 400. As Divisional Sanitary Officer he inspects the whole divisional area from the beach to the firing line; and in this case has a sanitary section of 20 men to supplement the sanitary work of the units. A more interesting job for a civilian medical man in this war could hardly be imagined. Fortunately the weather at present, though variable, is often heavenly, and we all hope to take part in the eventual success of our arms on the Peninsula.

With best wishes to all old Guy's friends, believe me,—Yours sincerely,

F. E. FREMANTLE,
Lt.-Col. R.A.M.C.T., D.A.D.M.S., 54th Div.

50, Waterloo Road, Bedford.
January 4th, 1916.

DEAR SIR,—You sometimes ask for copy, and it may be, when the accounts of Christmas festivities have appeared, that the enclosures may be of use. I think my friend Miss Lea gives a graphic description of her work and surroundings; the latter are something better now, I hear. No names, please.

The surgical case caused me some discredit at the time in the surroundings of a small provincial hospital, and much anxiety.

It may be that it is not unusual and that you may not think it worth publishing.—Yours faithfully,

WALTER A. E. WALLER.

Sister W. Lea, Q.A.I.M.N.S.R.,
18th Stationary Hospital,
M.E.F. (Island of Lemnos),
c/o G.P.O., London,
Nov. 19th, 1915.

Dear Mr. Waller,—It seems so funny to be writing to you from this queer out-of-the-way spot. It seems ever so much farther away than India ever was, because for days together we are cut off from anywhere by a howling gale and sand storm. There is one raging now; it started six hours ago, and the air is still black with it, and it looks like going on for ever. We have been struggling with tents all day which always seemed to be on the verge of collapsing (they often do), and everything we eat and touch is thick with sand. We can hardly stand against the wind, which comes all ways, and now that I am off duty I am excused dinner (there will only be cold bully beef and cheese to-night because I see the cook with his outdoor arrangements has given it up), and I have just hurried into bed to escape it all. We are sleeping in huts just now (our tents blew down over us), and although we have had every opening shut up all day and our ground sheets over the beds, I had to get a broom and sweep my bed first; the rest, of course, I have given up until the gale stops.

And yet to-morrow may be a glorious day, and the views and colouring on this barren island are really beautiful over the bay and the volcanic mountains, and the *sunsets* are more beautiful day after day than any I have ever seen. Twice we have been able to go on donkeys over the mountains, getting in a hot spring bath, a great luxury, I can tell you, as water is terribly scarce here, and we are only able to have about a saucerful of hot water in our green canvas baths once in a blue moon.

As to the work, it is very interesting and very much alive, but the censor is so strict here that I am not able to say anything. I have several tents of enteric to look after (eight in each), and sometimes plenty of dysentery and diphtheria, etc., as well, but they are kept in their own lines, of course. We have *plenty* of work, under great difficulties; plenty of flies and wind and dust; very little water, no butter, and all our food is tinned, except bread, and occasionally we get a sheep. We live on "rations," but most of the rations (such as porridge and butter can't be got), and at one time we were a week without bread; we cannot get potatoes, and eggs, 3d. each, are very, very scarce, but in spite of it all, now that we are acclimatised, we are very glad to be here; and the khaki folk, too, gave us such a welcome and are so glad to have us.

We have been to one or two camp concerts given by Colonials before leaving, and they were so weird and unforgetable I wish I could tell you more about them. We are just beginning after two months to get letters regularly from home, and it just makes all the difference, but I am afraid a good many of mine from here have got lost (torpedoed, I expect). Anyway, they all seem very well at home, and I hope you and Mrs. Waller are quite strong again now.

You would think our tents an awful muddle, I expect, but whatever we do they never seem to look respectable, and the orderlies are very few and untrained, and so many get enteric because they are such a seedy lot, poor things. The other day our letter tent blew down in the night, and letters and parcels were found in a very battered condition, so that really I think I had better be in time and wish you and Mrs. Waller a very happy Christmas, and I hope the Germans will keep the peace at home for *that* day at any rate.

How involved everything is just now, isn't it? And we are very much on the "qui vive" as to the next move. We hear very little *authentic* news, but reports without number, so that I am very glad of the *Daily Mails* Greta sends me. After we have seen them the patients greedily seize upon them because we are so terribly short of anything to read. They *are* bricks, these men, but so quiet and "close" compared with the Aldershot ones. They have terrible experiences in this part, and there seems to be no food to build them up before going back. It is all brought to the island, and all tinned, so that it is really wonderful that these thousands and thousands are so well fed, but it is not food for *invalids*.

Next day.—A glorious day, and quite cold and frosty. I have been a regular "Martha" all the morning trying to get the sand out of the men's tents, and found that one of those brilliant orderlies had been rubbing a man's back with his medicine. When I expressed surprise, he said, "Oh,well, if it is good for his inside, it must be good for his outside too!"

I wonder how you are liking your new surroundings now. I am afraid this winter will be a very sad and gloomy one at home, no lights and no sun make just all the difference. But the men out here are very cheery. I must stop now and get some tea, consisting of bread and margarine, and we can only occasionally get that, but we have splendid appetites.

With love and best wishes to you and Mrs. Waller, —From yours affectionately,

WINIFRED LEA.

A SURGICAL NOTE OF ABOUT THIRTY YEARS AGO.

As a final argument in a quarrel between a stud groom, of about 50 years of age, and his wife, the latter threw a bucket, which caused him to fall and fracture his thigh near the junction of the upper and middle thirds. There did not seem to be anything unusual about the case, and I treated him at his home with a long splint. As no firm union seemed to be secured after the usual interval I had him in our local hospital, where the chief treatment was gum and chalk or plaster splint along front of thigh and abdomen, with the whole leg swung at the knee.

After many more weeks the position seemed to be quite good, though there was a good deal of swelling of the upper part of the thigh, but still there appeared to be nothing firm about the bone. After a time at home, to consult a noted local bonesetter by the desire of his friends, he was re-admitted to hospital on the understanding that he should submit to amputation, but he hardly survived the operation at the hip-joint.

We found that the fracture had united in a capital line, but the bone was only as thick as an ordinary lead pencil. The head of the femur was perfect in shape, but was nothing more than a shell of bone, the cancellous tissue having been wholly absorbed.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

A London Student in Serbia.

From *The Times*, January 6th, 1916.

SIX WEEKS' JOURNEY TO DURAZZO.

INCIDENTS OF THE RETREAT.

THE following remarkable story of an adventurous journey by road through Serbia, Montenegro, and Albania, told by Mr. Vincent Drew, a student of Guy's Hospital, who went to Serbia last March as dresser and anæsthetist with the First British Field Hospital in Serbia, throws light upon the hardships undergone by the Serbians during the retreat of their armies befor the Austro-German and Bulgarian invaders. Mr. Drew, who returned to London a few days ago, immediately joined an Officers' Training Corps to prepare for a commission in the army.

At the beginning of October, said Mr. Drew, our mission was at Pirot. The Bulgarians were breaking their way through into Serbia, and our communications with Nish were threatened. In view of this, the Serbian authorities instructed us to proceed to Nish and thence to Krushevatz. I went on two days ahead with tents, surgical materials, and other baggage, worth about £5,000.

For days we did not get beyond the sound of the guns. Overhead, airplanes pursued us constantly, dropping bombs on the way. The road was choked with ox-wagons, two or three abreast, hospital cars, and a constant stream of refugees on foot. Every now and then the traffic was pushed to the side of the road to make a passage for guns and ammunition carts hurrying to supply the troops.

MEALS OF HORSE FLESH.

At Krushumlje the commander of the Third Army arranged to have my baggage taken by some gendarmes with ox-wagons, while I was given a pony to ride. It was a wretched beast, and had to be led a good deal of the way. Two days after leaving Krushumlje we encountered our first snow blizzard. Horses and oxen fell and died by the roadside. At first one saw a dead animal every few hundred yards, but, as time went on, there was one every ten or twenty yards. Now and then the bodies of men were to be seen with the bodies of the horses and cattle. We managed to spend the night under shelter, but many of the soldiers slept out in the snow with the splendid horses of the officers. Food had now become very scarce, but that day and the next, and, in fact, all the way, the troops plodded along, covering from 15 to 20 miles a day and in many cases going hungry at the end of the day's march. Some of them cut strips from the carcases of the dead beasts, and once or twice I ate some myself. Palings, doors, furniture —in fact, wood of any kind—was torn down to make fires.

At Prishtina, with great difficulty, we obtained rooms; and I was inclined to stop there in spite of the oncoming Austrians. My money was running short, and I did not see how I could get more. Food, even in Prishtina, was scarce and dear. I paid 8s. 4d. for a loaf of maize bread, stodgy stuff with little nutriment in it. It was thought there that in a day or two the Allies would be in Uskub and the way would be open by rail to Salonika. But the days passed and the Allies did not seem to be any nearer. So I set out again for Prizrend. In return for a good service which I had done at Krushevatz to the wife and daughter of a Serbian colonel whom I found at Prishtina, he secured a passage for myself and my baggage to Prizrend in a military motor-lorry. At Prizrend, the money problem having become more acute, I was once more on the point of giving it up. To go on through Montenegro to Albania meant crossing snow-covered mountains, and some sort of transport was necessary to carry food for the journey; but I had now nearly reached the end of my resources.

ACROSS THE MONTENEGRIN FRONTIER.

However, an American doctor was kind enough to lend me money, and Mr. and Mrs. Claude Askew, who had been with our hospital, gave me a seat in their motor-car. So we crossed the Montenegrin frontier, making for Ipek. Just over the border, at Jackovitsa, we were delighted to find some shops open. Bread, apples, and other fruit, and some tinned foods were bought, and we were happy for a time. I found a barber's shop open, and celebrated the return to civilization by having the first shave since I left Krushevatz.

Next morning we went on towards Ipek, but the motor-car stuck in the mud, and we had to wait until the night frost had frozen the road before we could proceed. We reached Ipek at 4 a.m. Mr. and Mrs. Askew went to one of the so-called hotels; but I was anxious to push on, so I looked about for a horse. Absurd prices were being demanded — £24 or even more for wretched little mountain ponies which at ordinary times would be dear at £4. Happily I found a man who had two sturdy ponies to hire at a comparatively reasonable charge, and I took both him and them. We started out for Podgoritza, on a road which went winding steadily up the mountains. After a couple of miles we entered a gorge, and the road became a bridle track along the mountain face, the ground falling away steeply at its side to a stream at the bottom of the gorge.

REFUGEES OF ALL NATIONS.

Along this road moved parties of refugees—Serbian peasants, Serbian officers, French doctors, Russian nurses; in fact, people of every class and many nations, the endless unceasing stream which had thronged the road all the way from Krushevatz. The first night out from Ipek we reached a small place with a few

huts, but the huts were full, and we had to sleep outside in the snow. I had a waterproof sheet to lie on, but the air was bitterly cold.

The second day took us right over the pass by icy paths where the snow had been crushed upon the rock, had melted, and had then frozen hard. The path in places was not more than a yard wide, and now and then one would hear a noise and, looking round, see a pack-horse rolling down the steep side of the ravine.

Up this slippery zig-zag path we climbed until we were at the top of the pass, and then we hurried down the other side, losing our way several times, but finally reaching by nightfall a little village below the snow level. Here, in a little café, I made a bed of a couple of forms. The next day it snowed hard, until the snow lay a foot deep on the road. We pushed through it to Andreavitza, whence in normal times a well-engineered motor road runs to Podgoritza. There I shared the last of my bread and other food with the owner of the ponies, and he turned back. Before he went he threw his arms round my neck and kissed me like a good Serbian comrade.

AT THE TOP OF THE MOUNTAINS.

In the place of his ponies I hired a horse and wagon, and resumed my journey. It was very trying to sit in the wagon, hungry and bitterly cold, going over a high mountain pass in a blizzard; but we stuck to it. That night we reached a little hut at the top of the mountains. Forty people were crowded into that hut, and we made the best we could of things. The only food I had was half a tin of condensed milk and some tabloid tea. The snow brought in on our boots had covered the floor in half an inch of watery slush; but we wrapped ourselves up and lay on the slush, thankful that at least we were indoors. The next day we toiled on, sometimes fording rivers, up to our waists in icy cold water because the bridges had broken down; and all the while the snow was falling pitilessly.

Late in the evening we came to a village where there were motor-cars, and by the good offices of the Serbian Minister of Finance I found a seat alongside the driver of a motor-lorry. Here I finished my tin of milk. I was never colder in my life than during the three hours it took us to get to Podgoritza. Our lamps would not work, and in the darkness we whizzed round hairpin bends at an alarming speed, with a cold wind biting our faces. At last we reached Podgoritza, where for the first time since I left Krushevatz, 21 days before, I was able to take off my clothes and get into bed.

From Podgoritza I went to Cettigne, and from thence to Skutari, to put myself under Sir Ralph Paget, who was in charge of all the British medical missions in Serbia. I spent several days at Skutari, but as sailings from San Giovanni di Medua were uncertain, a party consisting of orderlies, chauffeurs, and others, including myself, each man carrying food and blankets, started on foot for Durazzo. We were badly clothed; some of us had no soles to our boots; and we were all pretty thoroughly worn out. Through a tremendous thunderstorm we made our way to Alessio. When we got to the River Matcha the only means of crossing was by a ferry consisting of two logs lashed together and hollowed out. It took 24 hours to make the crossing. The fourth day found us trudging through mud which reached to our thighs. That night, after a wearisome tramp on rocky paths, we arrived with feet blistered and raw at a village not far from Durazzo. On the fifth day, December 18th, after a slow and painful tramp over a zig-zag switch-back mountainous path, we arrived at Durazzo.

In all, the journey from Krushevatz to Durazzo had taken six weeks. Three days later we sailed for Brindisi, and so home.

Appointments.

Royal Navy

D. M. P. Whitcombe has been granted a Commission as Surgeon for temporary service in H.M. Fleet.

Royal Army Medical Corps.

The undermentioned have been appointed temporary Lieutenants: W. E. Hills, W. Bligh, A. J. Beadel, L. Muir-Smith, A. Davidson, A. Barrett, C. H. Mossop, H. Mather, P. D. Scott, H. A. Watney, G. Ellis.

To be temporary Captains: G. Beley, H. C. Godding.

Territorial R.A.M.C.

Home Counties Field Ambulance: Lieutenant. A. C. Hayward to be Captain.

Northern General Hospital: Captain H. J. Smith is seconded for duty with East Anglian Field Ambulance.

Home Counties Divisional Sanitary Section: F. T. H. Wood, to be Lieutenant.

Wounded.

Captain A. L, Shearwood.

Honours.

Mentioned in Despatches.

The following officers are recommended in Sir John French's despatch dated November 30th, 1915, and issued from the War Office, January 1st, 1916, "for gallant and distinguished service in the field":—

ARMY MEDICAL SERVICE.

General Headquarters Staff.

Lieut.-Col. G. T. Rawnsley.

CONSULTANTS.

Major R. P. Lewis, Major H. Stewart.
Capt. E. Phillips.

Temporary Captains: J. A. Andrews, E. H. Griffin, W. G. Mumford, P. Smith, H. C. Godding.

Temporary Lieutenants: J. E. Barnes, C. G. Dunbar, C. S. L. Roberts (late temp. Lieut.), H. P. Costobadie.

R.A.M.C. (T.F.).

Major (temp.) J. W. Bird, D.S.O.
Capt. M. Coplans (London Field Ambulance).
Capt. G. H. Hunt (London Casualty Clearing Station).

Ward Concerts.

ASTLEY-COOPER.

Although we are barred from bringing the Christmas Festivities and the Old Year to a fitting close in the old Guy's fashion, with a bonfire in the Front Quadrangle, we still have our Astley Concert, the most enjoyable concert of the week. It was not so noisy towards the end as in former years, but it fully came up to its old standard of mirth and enjoyment. The lighting of the ward was very tastefully dimmed with lovely lampshades of orange, creations that had taken weeks of patient labour to make.

The concert started punctually at 7.45 p.m., with a pianoforte solo by Nurse Cox. Nurse Gibson-Sugars followed with a song which was encored. Nurse E. A. Smith gave us a violin solo; her beautitul playing was much appreciated and she was loudly recalled. Captain Briggs then entertained us with some very excellent, and somewhat mystifying, card tricks; he was also called upon to give us some more. Mrs. Carter then sang to us, and was followed by the Obediahs. They had given an excellent performance at the other concerts, but surpassed themselves in Astley. Mr. Davis as the heavy, swaggering, and sporting parent, and Mr. Forbes as the overgrown hobbledehoy of a Public schoolboy caused shrieks of laughter. Mr. Hirsch gave us a topical song, which was amusing if not entirely rhythmical. He started his performance with his excellent imitation of a chicken, this effort produced a large egg full of chocolates which he presented to Sister Astley. Mr. Attwater then gave us two excellent songs. An interval followed for tea and refreshments.

Nurse E. A. Smith started after the interval with more of her charming music on the violin, Messrs. Muir Smith and Knott then gave a duet the "Simple Melody," Mr. Knott sang "Susie Green" as an encore, and then followed the much expected "Guy's Sextette." They were, if possibly, more overdressed than usual in faultlessly cut morning suits, silk hats, so polished that they hurt the eyes, while their spats, monocles and silver-hooded sticks gave them the finishing touches. Great rumours had gone abroad concerning new songs, and new verses to the topical song "What! What! What!" and new verses and songs they certainly were. They also gave us selections from the programme that had delighted us during the week; if it is possible to make a choice, perhaps Mr. Kendall's "I love the Ladies," and Mr. Wilson's "What cher me old brown son," were the most enthusiastically applauded, while Mr. Woodruffe told us of his troubles in trying to match a piece of lace for the wife at one of our big department stores in the song "The other department if you please." Mr. Wilson as the "bookie," then put up for auction a postcard photograph of the Sextette. This was bought by one of our gallant officers from Stephen for 25/- which was given to sister for her ward. Songs were then called for. Mr. Wilson gave us "I'm in Love," Mr. Muir Smith responded with his old favourites of last Christmas, "On the Chesapeake Bay," and "On the 5.15," while Mr. Eccles gave us some of his old favourites, "The Village Pump," and "Mary Ann she's after me," all joining in the choruses in the usual fashion at this concert; Mr. Stallman sang, "My Motter, in his usual manner. The concert, after a few more songs, was then brought to a close at 11.15 p.m., with God save the King. Three cheers were heartily given for Sister Astley Cooper, and "for she's a jolly good fellow" loudly sung. Cheers were also given for the Sextette, Guests, and for those who had so kindly entertained us.

We then congregated around Guy's statue in the Front Quadrangle to sing Auld Lang Syne at midnight. Alas! how small our ring was. Cheers were given to Sir Cooper and the Matron, and for the President of the Residents and others, as fancy dictated in the spirit of the moment, while "for he's a jolly good fellow" was sung after each cheer. We then marched to the Nurses Home to the accompaniment of drums and songs, and serenaded them with "for they are jolly good fellows" and loud cheers; after which we marched to the Dressers' Room to Tip Top Tipperary Mary, On the Road to Dublin Town, and other songs of the week. Here we enjoyed ourselves to a late hour, with the excellent fare provided by the Dressers for the week, and ended the Old Year in song and mirth in the good old Guy's fashion.

DORCAS.

A small concert and tea were held in Dorcas Ward on Monday afternoon, December 27th. The Guy's Septette opened the concert with some topical songs, and were a great success. Mr. Collins followed with some character songs sung in costume, which were one of the most successful items in the afternoon's programme. During the intervals between his songs, Miss Ethel Cowan sang to us; Miss Winter entertained us with some recitations, while Mrs. Bevington gave us a few pianoforte solos. Unfortunately three people who were coming failed to put in an appearance, but Night Sister kindly brought Miss Fuller, who gave us several songs, which were much appreciated. Mr. Leviseur then gave us a comic dance in costume, and Master Raymond Stallman a few pianoforte solos. A most enjoyable afternoon was brought to a close by local talent furnished by the nurses and dressers.

EYE WARDS.

Held on Monday, December 27th, at 3.15 p.m., in Barnabas Ward, this concert met with the success for which all had hoped, and with the rose and Japanesque decorations the scene presented must have helped many a patient and visitor to forget their woes and troubles. Our thanks are due to Princess Iwya, of New Zealand, who sang delightfully, giving, among others, most fascinating Maori songs; and also to Mr. Grylls for his kindness in playing and accompanying in so masterly a fashion. Mr, Corey gave a brilliant musical sketch at

the piano, but unfortunately pressure of time prevented his appearing in the second half of the programme.

Before the interval Miss Messenger, kindly introduced to us by Mr. Burnside, Nurse Slade in an amusing character sketch, "Honesty," Messrs. Stallman and Knott also appeared.

The concluding half of the programme was mainly left in the hands of the Septette, whose dash, as usual, carried all before it, and needs no detailed description. Nurse Jordan sang splendidly, and Mr. Glover, doubtless as much to his own surprise as that of many amused spectators, discovered in himself a conjuror of no mean skill.

PROGRAMME OF CHRISTMAS ENTERTAINMENT.

Massa Johnson ... ... Mr. C. DEAN.
Big Drum ... ... Mr. F. A. KNOTT.
Side Drum ... ... Mr. R. A. HOLMES.
Tambourines ... Messrs. H. N. ECCLES, S. WILSON, and K. M. WOODRUFFE.
Bones Messrs. J. T. T. FORBES and M. B. M. TWEED.
At the Piano ... ... Mr. R. CURLE.

Scenery by "Saltmarsh."
Costumes by "Matron." Telegrams—"Teatotallers, London."
Coiffures for the nuts by Eustace Miles.
X-Ray Skirts by Spongebags, Ltd.
Lingerie by "Transparence et Cie."
Silk Stockings and Slides from the Nurses' Home.
Gags by "Lindsay Locke."
Bankers—Bright & Co. (Brighton go).
Classical quotations by "Ralph."
Take-in H.P.—"Margot."
Junior Assistant Radiographer—"Gracie."
Tea and Massage, a bob—at the Kiosk. (Caterers—Dives & Co.).
Personal attributes and biographies of the Artistes by Mr. Fagge.
If he can contain his mirth Mr. St. Allman will sing.
Dick Coulton will sing in Out-Patients.
By special arrangement our new cinema actor, Dr. Herbert French (death of Charlie Chaplin) will perform.
Punch and Judy Show in the Orthopædic Department,

Ladies requiring introductions to the Artistes should apply to—Reggie, "a-gent."

Pianos were kindly lent by the following firms during the Christmas Festivities:—

Keith & Prowse.	Bechstein.
Collard & Collard.	Stiles.
Steinway.	Chappell.
Blüthner.	Brinsmead.
Ströhmenger.	Wade.
Allison.	

Consulting Engineer's Report for the Year 1915.

The Treasurer,
Guy's Hospital,
London, S.E.

MY LORD,—I beg to enclose my Report together with Statement of Accounts for the Central Station for the year ending November 30th, 1915.

The Orthopædic and Tuberculosis Out-Patients' Departments and new Bacteriological Department referred to in my last report have been completed during the year and are now in use.

The Kitchen for the Henriette Raphael Nursing Home has been remodelled and enlarged.

It now includes separate rooms for washing up, for preparing vegetables and for cooking, together with three cold storage rooms.

Engine House Plant.

Additional refrigerating plant being required to deal with the cold storage rooms in the Nurses' Home above alluded to, and with the cold storage room in the Bacteriological Department, it was decided to remove the plant which had hitherto been used for the Mortuary and Pathological Department as this was too small to do the extra work required.

The new plant, consisting of two motor driven ammonia compressors, condensers, evaporator, brine pipes, tank, etc., has been placed in the extension of the engine room under Tabard House, where it is under the direct control of the Engineering Staff. This has now been completed and furnishes the means for cooling the Mortuary chambers, the cold rooms in the Pathological Department, the Bacteriological Department and the Nurses' Home Kitchen, and provision has been left for extensions as may be required.

The 120 k.w. set which I stated last year had been re-erected, has been set to work and found very useful in connection with the night load of the Hospital.

The main generating plant has been kept in good repair.

Boiler House.

During the year one of the economisers has been renewed. The boilers and the rest of the plant have been kept in good condition, and have been tested and passed as satisfactory by the Vulcan Boiler Insurance Co.

The amount of coal used in the Central Station in each of the last six years is shown by the following statement:—

Year.	Amount in Tons.	Cost. £	s.	d.	Remarks.
1910	4,437	3,665	7	10	
1911	4,456	3,694	4	2	
1912	4,641	4,217	3	9	Coal and transport workers' strikes.
1913	4.984	4,993	14	3	Coal dearer as result of strikes.
1914	5,114	5,206	8	5	War declared on August 4th.
1915	5,445	6,966	19	5	War.

It will be seen that more coal has been used during the year amounting to 331 tons which is caused by increased demands in the Hospital.

The cost of the coal has increased by £1,760 11s. 0d. This large additional cost is mainly due to the increase in price since the war.

Electric Light and Power.

Summary of Electricity used and Cost per Annum.

Year.	Units of Electricity used in the Hospital.	Cost per Unit (exclusive of Interest and Depreciation).
1911	302,450	0·98484d,
1912	313,710	1·01507d.
1913	327,030	1·00526d.
1914	336,889	1·07682d.
1915	337,650	1·11026d.

250 additional lights were connected during the year bringing the total number to about 5,330 in use in the Hospital.

96 additional plugs were connected making a total of about 1,336 plugs.

Eight additional motors have been installed which include five in connection with the Refrigerating plant, together with one driving the plate washer in the Kitchen, one driving a centrifuge in the Bacteriological Department, and one in the Electricians' Shop.

The motor driving the former refrigerating plant has been removed.

More than six miles of wiring have been used in connection with these extensions of which about one half has been lead covered.

The extra amount of current used during the year is 761 Board of Trade units.

The cost per unit has increased from 1·07682d. to 1·11026d, This increase is due to the extra cost of coal.

Maintenance charges are considerably less than last year as fewer repairs and renewals have been required.

Summary of Electric Lamps issued from Stock and Cost per Annum.

Year.	Metallic Filament.	Cost. £	s.	d.	Carbon.	Cost. £	s.	d.	Total Number	Total Cost per Ann. £	s.	d.
1913	1980	181	10	0	1850	46	5	0	3830	227	15	0
1914	1792	155	13	8	1761	44	0	6	3553	199	14	2
1915	1639	105	18	3	1031	25	15	6	2670	131	13	9

The smaller number of lamps used and the reduced cost is satisfactory, and testifies to the supervision which the Clerk of Works has exercised in dealing with these stores.

Heating and Hot Water Supplies.

The heating and hot water supplies generally have proved satisfactory.

The additions made during the year involved the use of about 2½ miles of new piping.

Bakery.

The machinery in the Bakery has worked satisfactorily, and it may be of interest to note that 51,116 quartern loaves of bread have been made and baked during the year in addition to 11,756 buns, and 152 lbs. of cake.

Surgical Cutler's Shop.

This has proved increasingly useful, the number of instruments dealt with during the year amounting to 9,622 as against 8,302 for the previous year.

Electro-Plating.

The arrangements for electro-plating which were nearly completed during the previous year have now had some 12 months of work, and have been of considerable use as will be seen from the following list of articles which have been dealt with:—

1,050 surgeons instruments.
310 hot and cold water taps.
7 infusion stands.
13 sterilizers and boracic pots, pipes and fittings.
6 metal operating stools.
4 forcep pots and brackets.
6 rings for bowls.
4 sets foot rest fittings for couches.
1 instrument tray and stand.
12 towel rollers and fittings.
100 feet of copper pipe.
12 test tube racks.
12 hypodermic stands.
4 large surgical leg splints.
20 plug washers and chains.
12 stays and chains.
72 anti-splashers for taps,
6 sets electric lamps and fittings.

In addition to the convenience of getting this work carried out on site as and when required, the cost is considerably less than the Hospital would have had to pay had these articles been sent away. The actual cost incurred for labour and materials for plating the above was about £74.

Laundry.

The machinery in the Laundry has been kept in good repair.

The callender beds have been tested and passed as satisfactory by the Vulcan Boiler Insurance Company.

I am, my Lord,
Yours faithfully,
(Signed) THOS. KIRKLAND.

Pass List.

University of Oxford.

The following candidates have been successful in the undermentioned examinations:

Forensic and Public Health:
A. Traill, D. Whitcombe.

Medicine, Surgery, and Midwifery:
A. Traill, D. Whitcombe, A. East.

University of Cambridge.

At the Examination for Medical Degrees, held during Michaelmas Term, 1915, the following candidates were successful.

SECOND EXAMINATION, OCTOBER, 1915.

Part II. Pharmacology and General Pathology:
J. M. Bickerton, T. Fernandez, F. N. Sidebotham.

Society of Apothecaries.

The diploma of the Society has been conferred on R. N. Craig, entitling him to practise in Medicine, Midwifery, and Surgery.

A Forgotten Obstetrician.

"In all the world ne was there non him lyk
To speke of Physik, or of Surgerye."
The Canterbury Tales—Prologue.

Of course, we had met before. But then it was in the luxuriant undergrowth of a Sussex hedgerow, where his quaint blackcoated figure, broad-brimmed hat, and little satchel were to be seen as he gathered simples for sterility or foul humours in the head—Tansie, and Violets, Willow leaves, and Bovage flowers—certain remedies when gathered by the light of the crescent moon. I had heard, too, from his own lips of how when the King lay at Oxford he was enabled by miraculous intervention to stay a grievous plague,—the light of the moon shining upon a monstrous rat, as he prayed to God to reveal to him the cause of this murrain. And how, then, reading the message aright he had ordered the townsfolk to slay every rat they could find and that then and then only would the plague be stayed. Had marvelled, too, at that medieval blending of simplicity and shrewd observation, the quaint racy turns of speech, the admixture of astrologer and herbalist, physician and divine. Nevertheless, to meet him again in this quiet spot where long custom had, I thought, precluded all possibility of surprise, came almost as a shock. A dusty, sunlit library, one of those dreamy places where, when the mood takes one, it is pleasant to browse for an afternoon amid the folios and in the octavos of forgotten polemics, dim echoes of controversies long since dead, worm-eaten commentaries on the epistles of St. Paul or the heresy of the Manichees. There amid the mouldering calf and vellum quartos of the Christian mystics, Tertullian, and Lactantius, the Thebiad, and the curious speculations of the elder Pliny, lying next to an old French version of Life of St. Theresa, I saw him, or as nearly as one may see a man dead for full two centuries and a half, a small calf-bound volume, intitulated a "Directory for Midwives." His name? I had forgotten; but let me give it you as he would have it—Nicholas Culpeper, Gent., student in Physick and Astrology. I can hear the discerning reader say with a sudden realization, "Why, I remember!"; for this is that same Nicholas whom we have all met, or nearly all, in the pages of Kipling's "Rewards and Fairies," and you recall, of course, the story he told to Dan and Una amid the gathering shadows of the old barn. So you can understand the eager pleasure with which I took the little volume from its dusty niche, by the autobiography of the ecstatic Prioress whose soul "made for Our Lord a bed of roses and lilies" to which she believed it "was impossible the adorable master would not come, though he may delay, and take his delight in her," and proceeded to the deciphering of his closely-printed pages. To give an adequate conception of such a perusal I should have to quote page after page *verbatim*, for in that way only could one hope to convey the savour of his prose and the shrewd aphorisms on Life, Death, and Government with which his works are liberally bespattered. Indeed, it is by quotation only that I can hope to convey something of the temper in which he wrote, this God-fearing old Royalist, who seems to have chosen medicine as a convenient platform to discourse to all who cared to listen of the vice and luxury of the age and the iniquities of the newly-established Commonwealth. Listen to the preface—the Proæmium, he calls it—telling of how he was inspired to write this work. "To the Midwives of England, Nicholas Culpeper wisheth success in their office in this world, and a crown of glory in that to come." "Worthy matrons," he continues, "you are of the number of those whom my soul loveth and of whom I make daily mention in my prayers. And having (upon fixed resolutions) consecrated the rest of my life to the Service of my country, in what knowledge I was brought up in, or have spent the greater part of my studies about: The moving cause of which was a serious consideration of the notable injuries offered to Men and Women by absconding the Rules of Physick from them or to no purpose. . . What insufferable Injury is it, that Men and Women should be trained up in such Ignorance that when they are Sick and have herbs in their Gardens conducing to their cure, they are so hoodwinked, that they know not their Vertues? . . The Consideration of this, put me upon it, to write Physick in my Mother Tongue. . . I conceived a few thoughts and I hope to bring them to perfect birth: viz., to lay down some rules whereby a man may as well prevent sickness before it comes, as a remedy for it when it is come." So in pursuance of these laudable sentiments he gives directions for the performance of Cæsarian section, the gathering of herbs and making of decoctions and unguents, rules to be observed in choosing a wetnurse and the avoidance of monsters, enlivening these dry and abstruse matters by astrological dissertations, and anecdotes from Aristotle and Vessalius. Indeed, one is tempted in perusing his genial pages to sigh for the halcyon days when physiology and embryology were not and the tedium of the *materia medica* was relieved by such prescriptions as the carrying about of a pigeon's head or a loadstone to prevent barrenness, and the wearing of a piece of a child's navel to guard against the Falling sickness and Convulsions. But let me proceed to a few extracts which will give you better than any mere descriptions some light on the practise of medecine in the first half of the seventeenth century. The date when conception took place was, of course, of paramount importance in determining the future prospects of the child, for, according to the qualities of his planet, so too would his own talents

vary.* To this branch of gynæcology, or rather embryology, Culpeper devotes several chapters, heading ing the section: "The formation of the child in the womb astrologically handled." "It cannot be denied," he goes on to say, "but that the stars and elements have a mutual sympathy one with another because they are produced out of one and the same *Chaos.* The elementary bodies are in subjection to the celestial, because obedience is to be found in the elementary world. That there must needs be microcosmical stars in the body of man, because he is an exact epitome of the Creation. That this microcosmical Sun, Moon, and Stars must be active, and the elementary of the body of man passive, appears, because the celestial are not changed, but remain the very same. . . To present this more clearly to your eyes as a truth, take notice, that the womb of a woman is under Scorpio; for under Virgo it cannot be for Virgo is a barren sign: And here by the way, That few or no writers that ever yet could read, could give any reason why Scorpio is a fruitful sign; they tell you a long tale of a tub concerning the rest of the signs, as that Leo is a barren sign because Lions seldom bring forth young. But why should not Taurus be a barren sign for bulls never bring forth young; and Aries is not fruitful, because it is the house of Mars, and why then should Scorpio which is the house of Mars also? The truth is (to let the fictions of authors pass) Scorpio is a fruitful sign, because it rules the Womb, and cancer and pisces are fruitful because they are of the same triplicity." These important matters settled, he passes to consider the causes of sterility in men and women. *Apropos* of the need for harmony between a married pair he tells the story of "two Theban princes, Eteocles and Polynices, both brothers, yet a mortal hatred began between them, that having slain one another in battle when their bodies were burned (for in those days and places they burned the dead corpse and entombed only their ashes) that the fire parted in the middle and went up in two tops; and if there were such a mummial hatred in their dead corps, greater must the hatred be in the seed of two disagreeing sexes."

There is a modern note, too, in the somewhat cynical reference to marriage as "a civil thing, therefore ought more properly to belong to the civil magistrate than to the clergyman, but the clergy get money by it, and that's the key of the business." For prolapse of the uterus the following is indicated: "Take a common Bur leaf (you may keep them dry if you please all the year) and apply it to her head and that will draw the womb upward: In the fits of the mother, put it under the soles of her feet, and it will draw it downward. Burseed beaten into powder will do the like, they command the womb which way they please. and by orderly usage will cure any disease of it. 'Tis a plant of Venus, and is best gathered when she is angular and strong in her hour, and the moon applying to her." An original remedy is the following: "A noble woman had on the right side of her face an ulcerated cancer; and when all the French, Italian, German, and Spanish physicians had seen it and could not cure her: a Barber cured her only with Chickens sliced thin, and laid on often every day." An awful warning is contained in the following anecdote: "A certain man of ingenious breeding and good wit (whose name I have forgotten) had a wife whose insatiable desire could not be satisfied for want of a boy, though she had many daughters, beautiful of person and of excellent understand and good conditions: But a boy she must have or else she dies. To answer her distemper (I cannot say her prayers) God gave her a boy, and he proved a fool; said her husband to her, Wife, thou wast never contented till thou hadst a boy, and now thou hast gotten one that will be a Boy all the days of his life." As a test whether a woman has conceived or no he gives two excellent methods. "Take a handsome green nettle, and put it into the urine of the woman and cover it close and let it remain in a whole night; if the woman be with child, it will be full of red spots on the morrow, if not it will be blackish. Or: Stop the urine of the woman, close it in a glass three days, and then strain it through a fine linen cloth; if you shall find small living creatures in it, she is most assuredly conceived with child, for the urine which was part of her own substance will be generated as well as its mistress." Perhaps, a few prescriptions taken almost at random may not be without interest. "A plaster: Take opoponax two ounces, Storax liquid half an ounce, Frankincense, Mastick, Pitch, Bole, each two drams, with wax make a plaster. For injection: Comfry Roots, an ounce, Snakeweed, Pomegranate Flowers, each half an ounce; Rupture wort, two drams, Yarrow Mugwort, each half an ounce, boil them in Red Wine. Then use Sulphur Balls. To strengthen the Womb, take Zedoary, Parsnep seeds, Crabs' eyes prepared, each a dram; Nutmeg half a dram; give a dram in powder." So, you see, they had a varied Pharmacopœia.

A prefatory note by his wife, Alice, states that her husband ("the stay and solace of my life") left seventy nine books of his own making in her hands, together with seventeen "completely perfected" in the hands of the bookseller, Mr. Cole. A respectable total, especially if all of them contain, as does the subject of this article, 350 pages. It would be interesting to discover how many of the original ninety-six still survive. Old Nicholas himself had a fine taste for num-

*Cf. Edmund's speech in King Lear: ". . . We make guilty of our disasters the sun, the moon, and the stars, as if we were villains by necessity, fools, by heavenly compulsion; knaves, thieves, and treachers by sperical predominence, drunkards, liars, and adulterers by an enforced obedience of planetary influence. . . . My father compounded with my mother under the dragon's tail, and my nativity was under *Ursa Major:* so that it follows I am rough and lecherous."

bers, as witness the following—"Nature hath ordained that a woman should conceive but one child in these and other countries especially, and that every year; yet in many places she hath more; one had five at every birth, twenty at four lyings-in. Margaret the Countess of Holstein, in the time of the Emperor Henry VII. had three hundred and sixty four at one labour. And another Countess in the time of Frederick XI. had 500 and 14 children at once, being boys." Perhaps, but as the Irish Bishop remarked when he read Gulliver's Travels, "I don't believe a word of it."

G. H. F. G.

Vapid Meditations of an M.O.

THE constant appeals from the GAZETTE must inevitably thaw the diffidence of the most sensitive of people, and I have often wondered why it was when there were so many of Guy's men scattered all over the universe, subject to experiences so diverse and always illuminating, with periods of enforced inertia, when the only thing to do was silently to meditate, why it was you should not be inundated with contributions of all sorts.

With this preliminary apology for the stuff which is to follow, I have seized my pen and am going to allow it to run over paper as it pleases. There is no need to be constantly weighed down by heavy responsibilities, the quality of contributions from a literary point of view does not seem to be of the greatest consequence, and, in fact, there is a sporting chance of anything being published—so here goes.

If one sits down and thinks—not necessarily at midnight as now—forgets about war for awhile, the strange surroundings of the man who was at the Hospital not so long ago must make its appeal felt. Above all, the new kind of mortal whom one comes in contact with cannot fail to make one think deeply and amusedly. I suppose the young practitioner starting in his career is always struck with the difference of mentality between him and the lay person. Infinitely more so, is it with Tommy and his officers.

The greatest mistake I made when first attached to a regiment, many months ago, was not to remember that they knew nothing about medicine and I knew everything. Never forget it, and never argue, but dictate! If you are asked what is the best biscuit or boots for Tommy, whether he should have brandy or beer, cigarettes or a pipe, you must know, or appear to know. I was rather amused when reading an article by some regimental R.A.M.C. man to find he said it was wise to know your C.O. personally, the Adjutant, and some Company Officers. Piffle! You should know the life-histories of every officer and his family and kiddies, you should know every man in the regiment as you know your favourite pipe and be able to diagnose his complaint 100 yards off.

Don't imagine all one does is to show heroism whilst under fire. It is preparation for scrapping which is just as important and takes up ever so much more of your time and everybody else's. As regards heroism, I never knew what fear was—until I got under fire for the first time. Hell! I shudder with disgust now to think what a horrible funk a man can really be in.

I often think the present army doctor must in many respects be very different from his prototype of some years ago, chiefly because he has a different type of man to deal with. In many cases discipline has only been possible owing to the quiet acquiescence of the more intelligent man in the ranks in it. The M.O. must always remember that his chief duty is to maintain the efficiency of men, and even to protect good willing men from those who are ill or would like to be. If you put a man "off-duty," somebody else is going to do that man's work. For all this, lightning diagnosis is essential, but only diagnosis as regards fitness or unfitness. Thank heaven, the thermometer and pulse and a man's looks never lie! A man will like you if you tell him he has got an "itis"; he will love you if you are able to reprimand him for having gone on duty when too ill. He feels a hero and returns later to tell his interested pals all about it.

The doc's name is much bandied about in barrack room, billets, trenches, and what he said and did is of moment. "The doctor said . . ." A *faux pas* is not easily forgotten. Officers who were in the ranks of the Regular Army years ago will tell you now how their M.O. lugged a tooth out, or sawed at a carbuncle, or painted iodine on a fractured collar-bone. Talking about iodine makes me think of a song I heard chanted by some men of a regiment—not far away. It sounded like "my darling Clementine," but only in tune, as the words concerned the faculty intimately, being all about the efficacy of the "number nine" and the soothing qualities of a "splosh of iodine."

Before proceeding on service, every Medical Officer ought to be provided with a manual dealing with complaints, preferably written by a layman, dealing with diseases which he himself has established. Of such a nature would be "rheumatism or rheumatics," "cold on the kidneys," "chill on the stomach," and it is hoped there would be a comprehensive account of the causes of certain maladies of which he is so sorrowfully misinformed, not infrequently contracts, but not unhappily attributes to bathing in the ocean or over-exertion on "fatigue." Why, please, is the liver blamed for so many horrid feelings when a man has intestines by the yard and many other internal viscera of no mean importance? In many cases, of course, the family doctor is to blame, and I cannot help thinking that very often scientific accuracy is sacrificed for the cultivation of the bedside touch.

One of the first things that struck me and made a deep impression on my mind was the ghastly failure

of the lay mind to grasp what life in the Services in war-time really meant. What a wonderful intricate machine it all is. Auntie and many people who ought to know better, imagine that all a man does when he enlists is to don his uniform, learn how to march on parade in a few days, to become hardy and powerful, then to rush over, jab his bayonet into a dozen of the enemy and return home perhaps with the V.C. That the whole system is nearly pyramidal, with the fighting, slashing, firing man at the apex and all the rest broadening towards the base is never comprehended. Does the average person know the work which is entailed in clothing, feeding, and transporting a single brigade? Of course, the sensational press and the lurid magazine foster these highly-coloured ideas, whereas men like Kipling and the writer of the "Green Curve" are much more correct and expressive. They've seen and felt.

If I ever get to practise on my own and I fail as the special sort of practitioner I set up to be, there will be one field still fallow. This wobbly imagination of humanity might very well be played upon. Treat it with magic and spells and wonders, do not tell it the truth under any circumstances, awe it with lights of vivid hues, electric machines and —scopes and —meters, and, as many of your patients will be almost perfectly fit, they will recover whatever you do, and you will be infamously rich with no conscience —a perfectly happy combination.

It is rather strange that whilst writing this in the fond belief of plenty of present and future leisure, we should get orders to be ready to move to-morrow to the land of sphinxes and mummies. I don't suppose my fur cap, just arrived, will be of much use there. I believe the best writers make a point of a good finish. I don't know how to do that, but most satisfaction may be given by just finishing. Voilá. L.

National Thrift Campaign.

Success of Cadbury Bros.' Scheme.

The Thrift Campaign instituted at the Bournville Works in June last for the benefit of the employees has exceeded all expectations. The firm offered a bonus of 5 per cent. on sums invested by their employees in Government or other approved trustee securities up to £100, and 2½ per cent. on amounts over £100 and up to £200. The total amount which has been invested under the scheme is £32,406, and the bonus paid by the firm £1,329.

In addition to the above, the sum of £8,090 has been deposited in the Works Savings Fund between June and the end of November, the number of depositors being 3,720. This amount is more than double that deposited in the same period for any previous year since the commencement of the fund in 1897 (the largest amount previously being £2,988 in 1913). Interest at the rate of 5 per cent. is now allowed on amounts left in during the year and at 4 per cent. on amounts withdrawn during the year.

Therefore, as a result of the firm's offer and the special campaign carried on during the last five months, the employees have invested and saved over £40,000.

Bournville,
December 1st, 1915.

The Organisation of the Nursing Profession.

THE war has brought many things to the searching light of criticism and the judgment passed upon their efficiency or failure in a time of crisis will have far reaching effect.

In the very nature of its work and its intimate relation with the effect of war the profession of nursing has literally been subjected to a national publicity foreign to its nature, and we are proud to acknowledge that the verdict given is all that its most devoted supporters could desire. It is impossible to say what the ministrations of each individual nurse must mean amid pain and horror.

However, to turn from the woman as a nurse to her profession as a class, chaos and disorganisation have been brought to light by the war and the leaders and true friends of the trained nurses see that the question of organisation has become imperative.

As our readers doubtless know, the advocates of State Registration combined some time ago and drafted a Bill which had a large majority on its first reading in the House of Commons, but which seems to have little chance of passing at present. The chief fault found with it, even by some of its supporters, lies in the constitution of the Council, which is likely to be a thorny point in any scheme of reorganisation.

Pending a possible State measure, is a voluntary scheme serviceable? Such a proposal is being made to all the large training schools under the auspices of the British Red Cross Society.

A voluntary combination of training schools to form a Nursing College, with power to arrange curricula, hold examinations, and grant certificates.

Australia has had for years such a system, which, being loyally supported, has become so strong that it is almost as powerful as law. Australia is now seeking State Registration, but the voluntary system has led the way and done useful work for years.

The first thing—the essential—is unity among the heads of training-schools; and for this—in a matter so controversial—compromise will probably be needed.

The following letter from the Hon. Arthur Stanley, Chairman of the Joint War Committee has been sent to the Boards of Management of all Hospital Training Schools—

83, PALL MALL,
LONDON, S.W.
30th December, 1915.

DEAR SIR,

During my past year's work as Chairman of the Joint War Commitlee of the British Red Cross Society and Order of St. John, I have been struck by the total lack of organisation amongst the various authorities responsible for the training of nurses and by the need for organisation amongst the nurses themselves. Occupying a neutral position in relation to these pressing problems I have given much time and attention to considering how,

in the interests of the public and of the nurses themselves, the present unsatisfactory condition of affairs may be remedied.

For something like twenty-five years there has been more or less active agitation in favour of the registration of trained nurses, but for causes into which it is unnecessary here to enter, this movement and others of a similar nature have hitherto failed to attain the object sought.

There is no unanimous feeling either amongst those responsible for the training of nurses or amongst nurses themselves in favour of any system of State Registration. Nevertheless I am convinced that something should be done at once to co-ordinate the various interests involved and, without prejudice to ultimate developments whether by legislation or otherwise, my own view is that for the time at least we must rely upon a voluntary scheme of co-operation amongst the Nurse Training Schools throughout the country.

I have confidence that a representative association would speedily attract so much support from the nursing profession as to lend great weight and authority to any decisions at which it might arrive.

Just as the Royal Colleges of Physicians and Surgeons through the Conjoint Board organise the teaching and examination of medical students, as the Chartered Institutes of Accountants, of Surveyors, Engineers, and other bodies, as Barristers and Solicitors organise the teaching and examining of candidates for entrance to their respective professions, so do I feel most strongly that now is the right time for some such movement in the nursing profession.

With this end in view it is suggested that a college of nursing shall be founded. This college shall be a purely voluntary body which will aim at securing the support and sympathy of the governors of hospitals to which nurse training schools are attached, of the leading members of the medical profession, of the matrons and lecturers at these nurse training schools, and last, but not least, of the trained nurses themselves.

I suggest that promoters of the college should be sought amongst the chairman and governors of leading hospitals, physicians and surgeons lecturing to nurses, the principals of nurse training schools and of nursing associations, and other persons interested in the education of women, and I hope your hospital may be willing in due time to nominate representatives to act in this capacity. The promotors, having obtained the sanction of the Board of Trade to the registration of the college with its memorandum and articles of association, should appoint the first council of management, two-thirds of whom should be matrons of hospitals or superintendents of nursing. For effective administration it is essential that the council of management should be relatively small in numbers, but in order to secure a proper representation of all interests, it is proposed that the council should form a large consultative board drawn from all classes of nurse training schools and nursing associations, and from nurses in practice throughout the country. Further, it is suggested that the council should always invite and receive a report from the consultative board before coming to a determination, either upon courses of study and technical training for persons intended for the nursing profession, or upon the conditions under which recognition may be extended to nursing schools. The council should also form an examination board, which will advise upon the appointment of examiners, the scheme for examinations, and the acceptance under safeguards of internal examinations in recognised training schools to qualify for the certificate of proficiency in nursing to be granted by the college.

In addition to examining and giving qualifications to nurses, the College should take power to exercise similar functions in all branches of women's work connected with hospitals, whether naval, military or civil, and to give certificates of proficiency to those who pass the necessary examinations.

Such are the broad outlines of the scheme, and I should be glad to know whether they meet with the general approval of your Hospital Committee. It is put forward with the idea of securing greater uniformity of training and curriculum for nurses, fuller co-operation between the Nursing Schools, and the better organisation of the nursing profession generally. I shall be glad to submit to the advisers who have already helped me any criticism you may be pleased to make. I have reason to hope that, should these proposals meet with sympathetic support, I may be able to secure financial assistance to launch the college in a suitable building, but before asking the Board of Trade's approval to omit the word "*Limited*" from the title of the Association I must be assured of a substantial backing throughout the country. When this step is gained, I shall have the pleasure of asking your committee to nominate your representatives to take part in the establishment and development of the college, which may I hope, promote the welfare of trained nurses and of all other women engaged in attendance upon the sick and wounded, and may thus do lasting service to our nation and country.

Yours faithfully,

A. STANLEY,
Chairman, Joint War Committee,
British Red Cross Society, and
Order of St. John.

It would be interesting to have the opinion of the readers of the GUY'S HOSPITAL GAZETTE, men and women, upon the initiation of a scheme from which its supporters hope lasting and far reaching benefits.

Births.

LOVAT.—On December 18th last, to Mr. and Mrs. Arthur Lovat, at 21, Carlton Crescent, Southampton —a son.

MANDY.—On 16th December last, at Quarry House, Hythe, Kent, the wife of P. S. Mandy, M.R.C.S., of a daughter.

F. A. K.

GUY'S HOSPITAL GAZETTE.

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Passim.

OUR present issue appears at a time when there is further change in our companions and surroundings, and the moment is good to express our appreciation of the men themselves who are leaving us, and of their services.

The past festivities and the finale provided by the Residents' Concert will provide an everlasting link of memory between those who have so enthusiastically supported the various functions, and even in such times, when patience, control and concentration are so sorely tried, all can look back with pleasure to the past few weeks and the companions they have brought.

To come even nearer home, we must mention the official retirement of Mr. E. N. Glover from the editorship of the GAZETTE. In a most difficult period of office he has grappled with the many obstacles confronting the successful publication of our little paper with splendid resolution and success, and although the character of the GAZETTE may be somewhat changed since the days before the War, we feel that he has kept it to its relative standing and lost none of its attraction to its readers. We give to him our sincerest thanks.

ONCE again, to refer to the festive season, we must mention the results of the sale of the Christmas Greeting Cards which Messrs. Ash & Co. annually present to the Hospital. The sales were as follows: Matron's Office, £14 10s.; Wills Library, £2 6s. 6d., resulting in the sum of £16 16s. 6d. being paid over as a donation towards the hospital funds. We express our appreciation and thanks.

WE note the appearance of the new issue of the Guy's Pharmacopœia, compiled by the Dispensary Committee, and published by Messrs. Ash & Co.

In the present edition has been included much from the British Pharmacopœal Codex of 1911, and from the supplement to that work issued in 1915.

The use of Trade and Proprietary names has been avoided as far as possible, but to facilitate reference during the time that these names are largely unfamiliar, a loose page has been inserted giving a list of such Proprietary Drugs with their Trade Names as included in the presented edition, together with the new proprietary names under which they may be found.

In all cases doses are given in both imperial and metric measures. and a useful, comparative table is provided.

ON a scrap of paper in the Gazette Office appears, in wandering Borough scrawl :—

Mr. Robins

I enclose my Rent the balance i will see you for on Monday morning as I want a fews words to speak to you about Mrs. Rumby.

We wonder of what arguments and heart burning these odd words may be evidence.

WE hear of the coming departure of the President of the Residents, Mr. C. Dean. He is shortly to take up military work, and we offer him our best wishes and congratulations, and hope as these notes are going into print that the audience in the physiological theatre will be giving him the applause born of an appreciation he richly deserves.

Obituary.

SYDNEY W. MacILWAINE.

Many a Guy's man of the middle and later "80's" will feel very sad on hearing of the death of their old friend MacIlwaine, or "Father Mac," as we used to call him.

MacIlwaine joined the hospital at a considerably later age than most, for, although he commenced his medical studies in the "70's" at Queen's College, Belfast, he was obliged to discontinue them for a time on account of ill-health. He then went to Natal, Australia, N.S.W., and later to Queensland, where, from 1879-1883, he took up cattle farming in conjunction with four of his brothers. In 1884 he entered Guy's and rapidly became an enthusiastic Guy's man, as keen as any young student, whether it was in connection with his work in hospital, in the "Artists'" corps, or in his support of the various sports and institutions of the School.

Himself a clear-seeing man he was from the first impressed by the practical nature of the training at Guy's, and later he exemplified it in his practice. After being appointed "Clinical," he later served as House-Surgeon to Mr. Clement Lucas, and then bought a practice in South Petherton, Somerset, where he worked for five or six years. He next proceeded to Red Hill to practise, and it was here that the chronic illness, to which he succumbed, first manifested itself to a serious extent, and ultimately led to his retirement from active practice in 1904 or 1905.

In October, 1901, MacIlwaine read a most interesting paper at the opening meeting of the Physical Society on "an attempted definition and classification of diseases on the basis of causation" (*vide* GUY'S HOSPITAL GAZETTE, 1901).

In his retirement he devoted himself largely to writing on this and other subjects in which he was interested, and in 1911 he published a book, "Medical Revolution," (P. S. King), which won high opinions in many quarters.

During the later part of his career at Guy's he married Miss L. Cross, a sister of an old Guy's man. He leaves three children—one son, a paymaster in the Royal Navy, and two daughters. At Guy's, MacIlwaine was a father, counsellor, and true friend to many of his younger colleagues, one who was always looked up to for his honesty of purpose, firmness of conviction, and contempt for all humbug. He was an enduring influence for good during his time at the hospital. Although some ten years older than most of us, yet he never appeared to be so, and it was his beard rather than his age which earned for him the sobriquet of "*Father Mac.*" To a man of his active mind his long illness was a sore trial, but he bore it as those of us who knew him well would expect. We mourn his loss as that of a faithful friend, a real good comrade, and an honest and upright fellow practitioner whose early withdrawal from the active practice of the profession could, indeed, ill be spared. J. F.

(For some of the notes about MacIlwaine's career we are much indebted to his brother, Mr. Herbert C. MacIlwaine.)

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

DEAR SIR,—I should like, if I may, to make known through your columns the fact that an old Guy's man, aged 44, invalided from the army, but quite strong and fit for general practice, would like to do locum tenens work upon reasonable terms for another old Guy's man. His difficulty is to find out who would be glad of his assistance in this way, and it occurred to me that the columns of the GAZETTE would be the best medium for finding out where his help would be most useful to another Guy's man.

Any communication upon the subject should be addressed to Dr. R. E. G. Phillips, at 62, Wimpole Street, W.—I am, dear Sir, yours faithfully,

HERBERT FRENCH.

62, Wimpole Street, W.
19th January, 1916.

DEAR SIR,—In July, 1915, I found by investigation at the Slaughter-house, that the intrapericardial pressure in a large number of newly-killed sheep and lambs was negative, and averaged 3 c.c. of water. In healthy men accidently killed, the pressure is similar. In men, dead of disease, the pressure tends to become atmospheric. As a result of this negative pressure, the pericardial fluid becomes of the same thickness all over the heart. Variations of this fluid, *e.g.*, quality, quantity, viscosity, specific gravity, etc., affect the beat, impulse, and sounds of the heart.

Treatment in the future may be definitely directed to the condition of this fluid even to the extent of aspiration. The sounds of the heart can be reproduced exactly by finger pressure on an undistended penny rubber balloon with a small quantity of water in it. Further experiments *in vivo* are at present being carried out.

G. ARBOUR STEPHENS, M.D.

61, Walter Road,
Swansea.

A Case of Recurrent Acute Thyroiditis.

F. W., æt. 23.

F. H.—Indefinite. ? similar condition in one sister.

P. D. I.—Has had "attacks" similar to the present for four successive winters, but has otherwise been perfectly healthy.

H. P. D.—December 3rd, 1915. He first felt ill with loss of appetite and feeling of weakness, had a "cloud" and "blue spots" before the eyes, and felt as though he would fall. He also had nausea and vomiting.

Swelling of the throat commenced on December 6th, 1915, and gradually increased in size, and became more and more painful until admission. During the period of swelling he had radiating pains over the mastoid region, he was also short of breath, and had a cough. During the night previous to admission, he says he had great respiratory distress, and had to "struggle for his breath."

On admission he looked extremely ill, and was very short of breath, and had a constant irritating cough, which seemed to originate from the trachea. There was a very large and tense swelling of the thyroid gland in which the whole gland, both lobes and isthmus, shared. This was extremely tender to the touch, and was hot to feel. Palpation even of the gentlest nature set up a severe fit of coughing. His temperature was 101·4, and pulse 104. He had orthopnœa. In two days his temperature had fallen to normal, and the thyroid had become very much decreased in size. By the fourth day the gland was just palpable, and all tenderness had disappeared. Since this date he has been pursuing an uninterupted recovery. No physical signs elsewhere could be detected to suggest a cause.

(Signed) CYRIL SHERRIS,
Capt. R.A.M.C. (T.C.).

Report of the Architect and Surveyor for the Year 1915.

To the CHAIRMAN OF THE HOUSE COMMITTEE,
GUY'S HOSPITAL,

Sir,—In accordance with the standing orders of my appointment I have the honour to furnish the House Committee with a report on my work as Architect and Surveyor for the year 1915, and I have included certain items which may, I hope, prove of interest to the Governors in reviewing the history of the past twelve months.

Out-Patient Tuberculosis and Orthopædic Building.—The new Out-Patient Tuberculosis and Orthopædic Building, commenced in the previous year, has been completed and fully equipped at a total cost of £4,573 12s. 3d.

Bacteriological Department.—Old and interesting portions of Guy's Buildings at the rear of the Chapel, formerly Chemical Laboratories and Theatre, were partially demolished in the year 1914, and new Bacteriological Laboratories are now constructed upon the site. These laboratories have been very completely fitted, and Animal Houses have been ingeniously provided over the roof. The Laboratories were opened in February of this year, and the cost totals £2,946 10s. 0d., exclusive of Architect's fees, and a large number of fixtures in the shape of cupboards, shelves, and fitted bookcases.

Henriette Raphael Nurses' Home.—A re-arrangement and extension of the kitchen accommodation at the Nurses' Home has been undertaken, and includes new cold storage compartments and a refitting of the cooking and washing appliances, all of which have been brought up to date. Including the necessary rebuilding of the sanitary block for the laundry and drainage alterations, the total cost, including the architect's fee, has been £1,186 18s. 10d. An extension to the Nurses' Dining Hall has been commenced, and when completed will give extra table accommodation for 52 nurses.

New Clinical Laboratories.—Three small Clinical Laboratories for the use of the Physicians and Assistant Physicians are in course of construction adjacent to the main staircase of Hunt's House. The structural work is nearly completed, and approved laboratory fittings are now being made in the Works Department.

Massage Department.—The southern portion of the top floor of Hunt's House, where, previous to the erection of Tabard House, the wardmaids were accommodated, has been transformed and fitted for the School of Massage and Remedial Exercises, with Cloak Room, Large Gymnasium, Massage Room, three Large Class Rooms, and Lavatory and lockers adjoining. All of the Special Appliances, Booms, Head Apparatus, etc., have been made in the Works Department. With the consent of the London County Council a tempo-

rary structure has been added to the Clinical Building, and provides waiting accommodation for over 80 patients for the Massage Department.

Hospital Repairs and Renovations.—The gross expenditure during the year upon works of renovation and general repair (£7,364 11s. 1d.) is somewhat less than for the previous year. In addition to the cleaning and distempering of wards, sanitary blocks, operating theatres—general external painting and some structural repairs have been necessary—the stone cornices and masonry at Hunt's House have been renewed. New impervious floors have been laid in Out-Patients' Obstetric Examination Room and the Out-Patient Surgeons' and House-Surgeons' Rooms, where the walls and woodwork, too, have been newly decorated. The Offices and Official Residences have been kept in repair, and ordinary works of repair and renovation to the Nurses' Home have been executed.

Some 4,000 windows and roof lights in the Hospital Buildings are periodically cleaned; about two-thirds are cleaned by the Works Department and the remainder, viz., the Nurses' and Staff bedrooms, School and College windows are cleaned by their separate employees. The area of glass totals nearly 2½ acres.

Many surgical appliances and hospital furnishings are made or repaired in the Works Department. Tubular furniture, sterilizers, hardware repairs, linoleum, hair, feathers, linen contracts, mattresses, pillows, blinds, upholstering, etc., cost during the year £1,063 0s. 2d. The following are some of the items:—

900 Crutches.
1050 Surgical instruments re-plated.
193 Mattresses.
294 Pillows.
112 Ward-bed curtains.
27 Couches and settees re-upholstered.
18 Easy and wheel chairs.
17 Wicker chairs.
30 Wedge pillows.
75 New window blinds.

It is of interest to record that pieces of anti-aircraft shells have been picked up during the recent enemy air raids on London, one weighing 14½ ounces, found in the Inner (Western) Courtyard of Guy's House, and another weighing 9½ ounces, found on the roof of the Out-Patients' Ophthalmic Department. These relics have been deposited in the Museum.

Aircraft insurance policies have been effected during the year upon the hospital buildings and in like amounts to the insurances against fire, viz. :—

Total amount of insurances against fire, £316,150; annual premium, £290 16s. 6d.

Total amount of insurances against aircraft, £316,150; annual premium, £316 3s. 0d.

A small fire occurred in a Pathological Laboratory on the top floor of Guy's House on November 8, 1915, which fire the foreman of works and men on the staff quickly extinguished. The claim for damage has been settled with the Insurance Company at £115 15s. 6d.

Works Department.—The workshops for the many trades of the Works Department, in particular joinery, masonry, plumbing, smithy, upholsterer, coppersmith, cutlers, electro plating, electrician, and engineering shops, are well fitted for carrying out the repairs and works to the hospital buildings.

During the year a large central store has been properly fitted, and all stores are now only procurable from the office of the Works Department. This system will, I feel sure, prove of monetary advantage to the hospital. The stock has been scheduled and priced at a total of £2,107 12s. 3d

Twenty-five employees of the Works Department have enlisted in His Majesty's Forces, and, in accordance with a decision of the Governors, 17 of these, being married men, are in receipt of half-pay. The single men receive no pay after enlisting. The following sets out a comparison of the number of employees and their wages at the beginning and at the end of the year :—

	No. of Employees.	Weekly Wages.	Married Men Enlisted.	Weekly Half-pay to Married Men.	Total.
		£ s. d.		£ s. d.	£ s. d.
Dec. 4, 1914	116	204 6 6	9	7 17 1	=212 3 7
Nov. 26, 1915	93	171 9 1	17	14 15 7½	=186 4 8

The number of employees, now reduced to a minimum for the works of repair and upkeep of the hospital buildings, has resulted in a reduction of £26 in the weekly wages bill.

In February last the House Committee granted an allowance of 2s. per week to all the Department employees for the duration of the war. This grant has amounted to £481 13s. 0d. for the year. The following is a copy of a week's wages account of the Department, viz., the week ending December 3rd, 1915 :—

	£	s.	d.
Fitters, Smith and Mate, Wiremen (Engineering Trades)	24	3	7
Engine Drivers, Stokers, Destructor Man (Engine Room Staff)	17	8	5
Carpenters, Bricklayers, Plasterers, Masons, Plumbers, Coppersmiths, Painters, Painters' Labourers, Scaffolders and General Labourers (Building Trades) ...	105	4	0
Upholsterer and Assistant	4	6	7½
Splint and Crutch Maker	2	7	4½
Surgical Cutler	2	0	9½
Orthopædic Fitter and Assistant	3	15	2
Sterilizing Man	1	8	8
Mess Room Attendant	1	12	11
Strong Room Attendants (2)	3	2	7
Window Cleaning (1), part week	1	8	7½
Sweep, Drains, Roofs, Lavatory Cleaner (1)	1	11	9½
Baker	1	19	8
Wages	170	10	2½
Half-pay to men enlisted	14	15	7½
Also Grant to Workmen (93 at 2/-) ...	9	6	0
Do. of Half-pay Workmen (17 at 1/-)...	0	17	0
Total	£195	8	10

The annual expenditure accounts under the Works Department for the last ten years are given as follows :—

	£	s.	d.
Year 1906	21,030	0	5
„ 1907	20,560	17	2
„ 1908	25,000	12	7
„ 1909	25,731	15	10
„ 1910	21,239	0	8
„ 1911	24,440	16	0
„ 1912	25,389	6	1
„ 1913	21,569	2	2
„ 1914	23,406	8	5
„ 1915	19,772	9	3

The College and Medical School Buildings.—The College and the buildings of the Medical School are in good structural repair; internal repairs and necessary renovations have been carried out at the College, but renovations are necessary at the Medical School. Estimates to carry out these latter repairs early in the new year are now under consideration.

Southwark Estate and Properties of the Re-Endowment Fund.—During the year repairs and renovations have been carried out to the properties of the Southwark Estate, in particular to small properties let on weekly tenancies, where improvements have been made in the habitable condition as opportunity occurred. In the interests of the Hospital a considerable annual expenditure is necessary on upkeep. All the properties are more or less old, and with few exceptions are not of good substantial construction. The conversion of four shops in Newcomen Street into dwelling houses, completed in December, 1914, at a cost of £130 4s. 4d., has produced an increase of rental amounting to £50 9s. 0d. for the year.

The annual gross rental of the estate has during the year been maintained, and in some instances upon a change of tenancies it has been possible to produce a slightly increased rental. With the exception of one small office property in Talbot Yard and one shop in Newcomen Street the whole of the properties are let.

The hospital has insured the properties of the Southwark Estate against damage by enemy aircraft. The total amount of insurance is £106,410 and the premium £138 14s. 2d. per annum, and a sum of £16 6s. 6d. has been secured from certain of the tenants as part payment of this year's premium.

I am, Sir,

Jan. 4th, 1916. Yours faithfully,

(Signed) WILLIAM J. WALFORD.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Guy's Hospital.

IN accordance with annual custom the House Committee publishes for the information of the Medical, Surgical, and Nursing Staff, the following Tables showing the total number of Patients sent during the past year to the various Convalescent Homes connected with the Hospital.

WARDS.	NUMBER OF PATIENTS, 1914	1915
Astley Cooper	65 ...	50
Bright	1 ...	—
Cornelius	38 ...	55
Lazarus	41 ...	57
Job	59 ...	83
Naaman	59 ...	49
Luke	57 ...	40
Evelyn	— ...	159
Patience and Samaritan ...	33 ...	130
Charity	29 ...	50
Dorcas	46 ...	50
Lydia	52 ...	79
Martha	66 ...	50
Eye Wards	13 ...	36
Addison	61 ...	56
Mary	51 ...	55
Stephen	40 ...	—
Esther	56 ...	73
Queen Victoria...	51 ...	101
Clinical	70 ...	61
Isolation	— ...	—
Surgery	1 ...	—
Out-Patients	37 ...	53
Light Department	2 ...	—
	928	1,287

The subjoined list gives the distribution of the patients amongst the various Homes :—

Ascot Priory	288
Bexhill (M.C.I.)	40
„ (Little Common, M.C.I.)	63
Bognor (Merchant Taylor's Home)	157
Broadstairs (M.C.I.)	146
Bromley (Brackenhill)	3
Cobham (Schiff Home of Recovery)	68
Croydon (Wallacefield, for wounded soldiers)...	17
Hadley, Barnet (Children's Home Hospital) ...	8
Highcliffe-on-Sea (The Burns Home)	130
Rustington Convalescent Home	15
Swanley (Parkwood)	174
Walton-on-Thames (M.C.I.)	110
Weybridge (Mrs. Heald)	3
	1222

SANATORIA.

(Beds allocated free of charge to the hospital by the King's Fund; travelling and incidental expenses, only, paid by the Samaritan Fund) :—

Didworthy (Devon and Cornwall Sanatorium)	7
Holt, Norfolk (Kelling Sanatorium)	14
	1243

In addition to the above, 44 patients have been sent to various places for convalescent treatment, principally in co-operation with the Charity Organisation Society and the Invalid Children's Aid Association 44

1287

List of amounts received from Patients in the various Wards, and sums found in Ward Collecting Boxes, etc., for the year ending December 31st, 1915. The amounts received in the previous year are inserted for the purpose of comparison.

	Box Collections. 1915. £ s. d.	Special Donations. 1915. £ s. d.	Totals for 1914. £ s. d.
Front Gate Box ...	3 4 9	—	4 16 0
Porter's Lodge ...	2 17 11	—	2 16 0
Out-Patient Dept.	4 15 11	5 4 0	6 13 2
Surgery	8 9 0	10 10 0	14 19 5
Dental Department	3 8 10	4 2 0	5 18 9
Light Department	3 12 11	14 7 0	17 16 0
Massage Department	39 2 11	15 4 0	— 16 4
WARDS.			
Addison	1 8 11	12 10 0	26 15 0
Astley Cooper ...	0 15 1	29 3 0	10 4 11
Bright	1 16 2	81 11 0	28 9 0
Charity	3 10 1	32 0 6	34 16 7
Clinical	1 2 9	7 2 0	13 11 2
Cornelius	0 5 4	24 14 0	25 17 6
Dorcas	23 7 3	11 10 0	35 1 9
Esther	1 3 2	33 13 0	11 16 11
Evelyn	2 9 11	15 13 0	5 14 8
Eye	8 11 0	19 0 0	12 15 8
Job	5 2 6	25 12 0	34 2 6
Lazarus	0 18 11	48 14 10	32 0 8
Luke	3 1 11	17 0 0	48 2 7
Lydia	3 3 2	7 2 0	19 14 1
Martha	2 7 2	63 0 6	46 17 5
Mary	1 18 3	17 15 0	13 2 4
Naaman	6 15 0	40 13 6	48 18 0
Patience	2 5 6	11 11 6	15 18 3
Queen	7 5 8	96 2 0	31 18 6
Stephen	6 5 4	122 10 0	68 13 6
	£149 5 4	£766 4 10	£618 6 8
Total for 1915.	£915 10 2		

Pass List.

Royal Colleges of Physicians of London and Surgeons of England.

At the First Professional Examination of the Conjoint Examining Board, held on January 4th, 5th, 6th and 7th inst., the following candidates were approved in the *undermentioned subjects*:—

Chemistry and Physics.

Edward Rowan Boland, Harry Norman Shapiro.

Chemistry.

Guy Kingham Reeves.

Biology.

Edward Rowan Boland, Samuel Hyman Coplans, John Beaumont Gregor, Eric Hardy, Mohammed Arthur Razzak Khalifa, Hubert Stanley Morris, Guy Kingham Reeves, Harry Norman Shapiro.

Royal College of Physicians of London.

At the Second Professional Examination in Anatomy wnd Physiology, held on the 6th, 7th and 10th inst., the following candidates were successful:—Charles Reginald Cade, Harold Octavius Long, Arthur Arnold Osman, Arthur Llewellyn Spencer Payne, Adolp Gladstone Millott Severn, Samuel Anthony Withers, Sidney Woolf.

At the Quarterly Examination in Practical Pharmacy, held on January 13th, Robert Aspinall-Stivala was approved.

University of London.

FIRST M.B.

At the examination for Medical Degrees held recently, Saul Cohen was approved.

Society of Apothecaries of London.

At the Primary Examination (Part II.) held on January 3rd, 5th and 6th, the following candidates were approved:—

Anatomy.—C. C. Bennett, T. G. D. Bonar, C. V. Brown, F. K. Escritt, St. G. B. D. Gray, E. H. L. Le Clezio, H. O. Long, C. Moffatt, A. A. Osman, A. L. S. Payne, F. G. Peters, R. S. Ralph, S. H. Robinson, C. D. G. Siggs, W. H. Simmons, W. Skelly, W. H. Steavenson, R. W. Warrick, E. R. Webb, S A. Withers.

Physiology.—C. C. Bennett, St. G. B. D. Gray, T. G. D. Bonar, G. H. L. Le Clezio, H. O. Long, C. Moffatt, A. A. Osman, A. L. S. Payne, G. F. Peters, R. S. Ralph, S. H. Robinson, A. G. M. Severn, C. G. D. Siggs, W. H. Simmons, W. Skelly, W. H. Steavenson, R. W. Warrick, E. R. Webb, S. A. Withers.

Royal College of Surgeons of England.

At the Preliminary Science Examination for Licence in Dental Surgery, held January 4th, 6th and 7th, the following candidates were approved in the undermentioned subjects:—W. D. Hatton, Stanley V. White, Eric F. Wilson.

Change of Address.

W. Sampson Handley, M.D., F.R.C.S., from 12, New Cavendish Street, to 36, Harley Street, W. Tele.—Mayfair 422.

F. D. Saner, M.B., B.C., from 14, Milner Street, Sloane Square, to 173, St. James's Court, Buckingham Gate, S.W.

Richard Felton, M.B., Rosemount, Swannerton Lane, Dartmouth, Devon.

Stanley Wickenden, R.A.M.C., from 48th Field Ambulance, to 90th Field Ambulance, B.E.F.

Major J. Wallace Kemp, R.A.M.C. (T.), 41c, London Road, Forest Hill, S.E., or c/o Messrs. Holt & Co., Bankers, 44, Charing Cross, W.C.

(The Editor will be very glad to receive a post card with notes of any change of address.)

Infection of the Colon by the Blue Coliform Bacillus.

CLINICAL LECTURE BY A. P. BEDDARD.

CASES of this infection are fairly common; they are interesting because the clinical picture is variable, and satisfactory because they are generally curable.

The blue coliform bacillus is morphologically and culturally very like the bacillus coli communis. It does not, however, ferment lactose, and therefore, when grown upon nutrose plates stained with neutral litmus, the colonies appear blue instead of red. It is not highly pathogenic to animals. The same is true of man, in whom it is a purely local infection without septicæmic manifestations.

The anatomical change in the colon is catarrhal, never ulcerative, unless the bacillus is associated with some other organism such as the streptococcus longus, to which the ulceration is due. The motions, therefore, even in an acute attack, do not contain blood.

The symptoms are of two kinds—intestinal and constitutional.

A. INTESTINAL SYMPTOMS.

1. *Production of mucus.*—This is always excessive, but varies both in quantity and appearance. It may appear as opaque membranes or lumps apart from the fæces, as in a typical case of membranous colitis, or as flakes on the outside of a solid motion, or as clear jelly scattered throughout and easily overlooked in a loose motion.

2. *The regularity of the bowels* is generally disturbed, but again is very variable both in the same and different cases. In some cases there is more or less chronic constipation with scybalous motions and the passage of membranes or large lumps of mucus. In other cases solid motions or a tendency to constipation alternates with loose motions or a tendency to diarrhœa. In one case the cycle of constipation alternating with diarrhœa was gone through with almost perfect regularity every three weeks; in other cases the periods succeed each other at long and irregular intervals. Some patients always pass loose motions. It may be only one a day. If more than one, generally in the early part of the day, less often at night. Occasionally such patients possess in addition an excitable colon or gastro-colic reflex, so that they pass a motion on the least excitement or after a meal or hot drink.

3. *The character of the motions* often suggests the diagnosis. When scybalous there may be nothing characteristic about them. When soft or loose they contain much unaltered bile-pigment; they are not brown, but yellow. Patients may describe them as being as yellow as a baby's, or like yellow putty, or as being spongy, aerated and floating in water.

4. *Abdominal discomfort* may be absent. When the motions are scybalous, with much mucus, severe attacks of colicky pains are common. When the motions are loose, patients may complain of a general uneasy feeling and burning sensatfon.

B. CONSTITUTIONAL SYMPTOMS.

These are due to the specific intoxication from the bowel.

1. *Pyrexia and acute illness* are rare, except in very acute attacks or exacerbations in children associated with much diarrhœa and clear mucus. In most cases the constitutional disturbance amounts to ill-health rather than illness, and the symptoms are correspondingly vague.

2. *The usual symptoms* are headache, lassitude, bodily and mental, and a poisoned feeling which is frequently described as being worse on waking, and gradually decreasing as the day goes on. Male patients assist one's intelligence by mentioning the morning after a convivial evening. The tongue is dirty and the appetite is poor, associated apparently with marked hypochlorhydria. The degree of these symptoms is definitely related to the state of the bowels; the patient feels better when he is constipated, and worse when his motions are loose and yellow. Purgatives aggravate the symptoms. Patients frequently find out that to treat their constipation or bilious symptoms with purgatives is only to make themselves feel worse. When the bowels are loose exercise generally increases the poisoned feeling next morning.

3. *The clinical appearance* varies like everything else. Some patients look more or less well, others of them, and especially those with very loose motions, look in different degrees pale, unhealthy, weary, harrassed, pigmented and toxic. The general characteristics of some children are quite suggestive of the diagnosis. You see a pasty-faced unhealthy-looking child who is not necessarily grossly under the proper weight or height, but is peevish, irritable, easily tired in body and mind; who obviously never

eels well and vigorous, and only brightens up for a short time when some new excitement is offered to it.

The diagnosis is necessarily bacteriological. The best material to pick out for culture is mucus, and failing that, some of the loose or putty-like motion. If you see a patient during a constipated interval, when the motions are more normal in consistency and colour, it is possible to take a minute fragment of fæces for culture after a negative result. In such a case it may be necessary to examine several specimens of fæces at intervals, or to wait for mucus or a loose yellow motion.

Merely to find an abnormal organism, such as the blue coliform bacillus, is not to prove that the patient is suffering from the infection. To prove this it is necessary to show that the blood serum contains specific agglutinins.

In patients who come complaining of colitis as they tell you, or of abdominal discomfort with chronic or intermittent diarrhœa, a bacteriological examination of the motions obviously suggests itself. But this is not always so if the patient complains of chronic constipation with attacks of colic and the passing of membranes or lumps of altered mucus. Such patients are liable to be diagnosed off-hand as cases of membranous colitis and treated accordingly. There is such a case in the hospital at the present moment, a naval officer who has on several occasions received Plombières treatment at Harrogate, always followed by benefit but never by cure. His motions give an almost pure culture of the blue coliform bacillus which his serum agglutinates in a dilution of 1 in 200. I have seen other and similar cases in children as well as in adults. Whether such cases should or should not be included in membranous colitis depends entirely upon one's definition of that complaint. The practical point is that there are cases clinically indistinguishable from membranous colitis in which the condition is due to a specific infection as contrasted with the majority of cases of this complaint in which the bacteriology of the motions is normal.

The diagnosis in some cases is much less obvious because the patient does not mention or has no abdominal symptoms. He may describe his bowels as being regular and may not mention his loose yellow motions because he looks upon it as a natural result and not as connected with the cause of his "biliousness." The patient in fact complains only of the constitutional disturbance due to the intoxication; physical examination may reveal nothing abnormal; the urine frequently contains no excess either of indican or of indol-acetic acid.

Yet other cases are obvious examples of the condition of mental exhaustion which we call neurasthenia; in such cases it is probable that the intoxication has helped to bring about their break-down. To say, however, as is being said, that neurasthenia is always due to alimentary intoxication, is going very much too far. In my experience the bacteriology of the fæces of neurasthenic cases is frequently, if not generally, normal.

Some patients only complain of a windy, uncomfortable and feeble digestion, which appears to yield neither to medicine nor to diet. The naval officer whom I have already mentioned suffered gastro-jejunostomy at the hands of an enthusiastic surgeon who made no effort whatever to investigate his case.

Treatment.—A certain amount of symptomatic treatment may be necessary.

Constipation should not be treated by purgatives, but by paraffin; a warm olive oil injection overnight and a warm water enema or colon wash-out in the morning. If a purgative must be given, then castor oil is the least objectionable. Treatment of the constipation by a diet rich in cellulose, such as would be appropriate for an ordinary case of membranous colitis, is in my experience not successful: it is either too much for the patient's digestion or goes to the other extreme and produces diarrhœa. In so far as constipation is due to this disease, it is permanently relieved as the cure of the infection progresses.

Diet is of quite secondary importance. Many patients can digest a simple mixed diet and are not benefitted by restricting it. Patients with a feeble, windy digestion and marked hypochlorohydria have to be dieted like any other case of atonic dyspepsia. They find that if they overload their stomachs they not merely have indigestion but also aggravate their internal trouble. There is a certain school of thought prevalent in certain parts of the Continent which appears to see in diet the one and only treatment for all kinds of colitis, and in fact one might almost say for nearly all disturbances of the alimentary tract. This attitude certainly underestimates what medical treatment can do for the cases we are considering.

Drugs are of no great value. An acid, bitter mixture like Mist. Acidi Co. may be required to help the digestion. Abdominal chills are certainly to be guarded against. Strong exercise and fatigue, if they react on the state of the

bowels and the symptoms generally, have to be avoided.

Vaccination is the only curative treatment of which I know. The doses are increased in size according to some such plan as the following, 5, 10, 25, 50, 100, 250, 400, 500 millions. They are given at intervals of 5 to 7 days for the smaller doses, and of 7 to 10 days for the larger. For about 24 to 36 hours after an injection there may be slight headache and lassitude, in fact an aggravation of the toxic symptoms. It is wise to repeat the same dose two or three times, until it produces no discoverable effect, before going on to a larger dose. When the really large doses are reached and the patient is getting on towards complete cure, symptoms referable to a negative phase are absent. As a rule the patient does not notice any very great benefit from the treatment until about six injections have been given.

Unfortunately the treatment is a long one; and of this the patient must be warned beforehand. I have never seen a cure produced in less than 6 to 9 months, and it may take 2 years. By cure is meant not merely that the patient is free from all symptoms, but that repeated examination of the fæces fails to show the presence of the bacillus. We have already seen that when the abnormal bacilli are less numerous, the small fragment of motion used for cultivation may not produce any colonies on the plate: and yet the colon as a whole might still contain some of the organisms. In order to guard against this obvious fallacy, it is wise to continue vaccination for at least three months after cultivation has first failed to show the presence of the bacillus. It is not always easy to persuade a patient who feels perfectly well that it is necessary to go on treating him when he is apparently cured; I have known several cases which have relapsed in consequence.

Before embarking on a long and costly treatment some patients want to know what chance they have of spontaneous recovery without treatment. A priori it is extremely unlikely that the body never puts an end to such an infection; it might in fact be the rule, and not the exception, that it does. But from analogy it would be also probable that the longer the infection has lasted the less likely is spontaneous cure to take place. Patients not infrequently give a history of symptoms extending over many years; in one case the period was twenty-five.

Another question which generally arises before the treatment begins is whether you can guarantee a cure by vaccination. To say "yes" would be foolish, and to say merely "no" would be to misrepresent the prognosis. Most patients are cured sooner or later. In many the treatment proceeds without a hitch and the method seems delightfully easy and simple. But difficulties may arise. Perhaps the most frequent is spontaneous exacerbations of the infection. Either a chill or indiscretion of diet or fatigue or some unknown factor is followed by an outbreak of yellow motions, mucus and constitutional symptoms. Vaccination has to be stopped until the symptoms have begun to improve and is then resumed in doses according to the severity and length of the attack which will be a half or less of the last dose.

The most difficult cases to treat are those in which there is chronic diarrhœa with several loose yellow motions a day and marked toxic symptoms. At one time one may appear to be getting the symptoms under control only to find later that one has not; one dose of vaccine may produce but few symptoms, and the same dose given in a week's time may cause severe symptoms lasting for days. The explanation presumably is that such a patient practises auto-inoculation on a large scale and at irregular intervals, which makes treatment by vaccination almost impossible unless one can limit and get the auto-inoculation under control by placing the patient in bed. The only patient whom I have so far failed even to improve by vaccination is needless to say a medical man who can not afford to lie up in bed for symptoms which are just bearable.

The last point in treatment which we need consider is the question of mixed infection. Besides the blue coliform bacillus it is not unusual to find the bacillus lactis ærogenes or streptococcus longus. The bacillus lactis ærogenes can be safely neglected. In regard to streptococcus longus we are not considering cases in which it is causing ulcerative colitis, but those in which its presence does not appear to alter in any way the character of the motions or the symptoms of the particular disease under discussion. The practical point is whether or not we shall use a streptococcal vaccine in addition to the other. My experience of streptococcal vaccines in infections of the colon is that given up to doses of 1000 million of a sensitised vaccine for several years they will reduce but not put an end to the infection. Nevertheless I am under the impression that when both streptococcus longus and the blue coliform bacillus are present, it is better to use vaccines of both organisms than of the bacillus alone.

The Position of Women.

I.

IT used at one time to be impossible to speak of woman in relation to her place in the community without sundry persons speaking insinuatingly or significantly as the case might be of the "sex problem." What this "sex problem" business was (beyond the rather obvious truism that women are women and men are men) it was difficult to fathom. It was, indeed, only a symptom of that sex obsession which accompanied the rise and decline of the militant movement—an interesting manifestation of the decadence which invariably accompanies times of prosperity—an obsession which, as I pointed out two years ago in these columns, seemed to threaten our national sanity. The whirligig of time, however, brings its revenges, and the public mind, as the papers ironically put it, being occupied elsewhere, the very remarkable changes that are taking place in the economic and industrial status of women, not only in England, but throughout Europe, bid fair to pass unnoticed. It is my intention, therefore, in this paper to discuss briefly the extent and significance of this incursion of women into man's industrial sphere, and in an ensuing article to venture upon a few speculations as to its bearing upon the remote future.

When the war broke out in August, 1914, women were, industrially, much as they had been for the last twenty years. That is to say, their labour was invariably paid at a cheaper rate than corresponding work done by men. The feminist agitations for equal pay for equal work were rather ignored, as, indeed, they were bound to be since, from an electioneering point of view, their support would carry with it no votes, or met by the specious argument that a male worker had his home to support, whereas the woman was working for herself alone. The rates of pay were appallingly bad, the women had little or no efficient trades union organisation to enable them to grapple successfully with the rascally employer. Thus, the 1911 census gives a total of 5,854,036 women employed "in gainful occupations." This total of close upon six million working women and girls excludes all those who were engaged in unpaid domestic work at home. More than half the female population of these islands between the ages of 15 and 25 was thus at work for hire. For 1915 the estimated number is 7,000,000. In fact, at some time of their lives the great majority of British women are wage earners; from 18 to 20, the most employed age, over 70 per cent. are in employment. Of the females in manual work, out of a total of 4,600,000, the wages of no fewer than a million fall below 12s. per week, the average for this class for a full week's work being 9s.; a million and a half earn from 12s. to 15s.. and only half a million rise above the 15s. level. Among the rest, a million and a half are girls whose average earnings are 7s. 6d., and 100,000 casually employed females whose weekly takings reach the astonishing sum of 3s. 6d. For the total number of adult women the wage averages out at 10s. 10½d. for a week of at least 72 and generally 80 hours work. The reasons for this low standard of payment form an interesting page of social history. Throughout the middle ages the status of women in marriage, and especially when one considers the communistic form of both urban and rural life in those days, of the single woman as well, was infinitely higher than it became upon the advent of industrialism. Many people believe that it was only in the nineteenth century that women began on a large scale to work for their living. No greater mistake could be made. The evidence all goes to show that before the eighteenth century women worked as hard and as long as men did. In the sixteenth century women not only helped their husbands in farm work, but they toiled at spinning and carding of flax and wool as a by-industry of their own. In the town the merchant's wife exercised an active supervision over the goods and apprentices. But the basis of women's work then was quite different from what it is to-day. Speaking generally, before the industrial revolution the economic unit was the family, and not the individual. So much was this the case that the censuses of 1811, 1821, and 1831 assumed that all the members of the family would practice the same occupation. Much of the work done by women in the family was of a domestic nature for the immediate service of their husbands and children, and not for profit. The production of many household commodities — butter, pickles, ale and cider, cordials, jams, bread and cakes, spiced meats, linen and woollen garments, scents, and even drugs (or, rather, decoctions of simples), fell to the lot of the housewife, besides the care of the poultry and young and ailing animals of all kinds. In this she was aided by her own unmarried daughters and those of the wives of labourers in her husband's employ who had no imperative domestic ties. In fact, before the nineteenth century marriage was an industrial partnership as well as a relation of affection, since the wife contributed almost as much as did the husband to the welfare of the household. Moreover, her activity was not confined to the production of use values, but of exchange values as well, since she sent her surplus butter, cheese, eggs, linen and woollen fabrics, etc., to the markets.

But the industrial revolution, and by that is meant the introduction of machinery, and the taking of work out of the home to the factory, resulted in the break up of the family as an independent economic unit by diminishing, and in the end entirely supplanting, the production for use carried on in the home. All the multifarious activities of the old-time housewife were under the new conditions carried on in the factory, and the vast system of profiteering and exploitation of women's labour may be said definitely to have

begun. Inevitably this reacted upon the position of women, whose relations to the family were always closer than those of men; and the changes in the nature and aspirations of women which have developed in the nineteenth century are very largely, though not entirely, due to these altered conditions. Unceasing toil had always been the lot of the poor woman, and so she drifted without difficulty into the new forms of employment. But it soon was found that in this new sphere they were no longer partners, but rivals, of men, working longer hours for less wages and under worse conditions. In the agitations which preceded the first demand for factory legislation, it does not seem to have been realised that it was the underpaid work of women and children that resulted in the low standard of payment for men, and it was in the teeth of public opposition that the first of the Factory Acts was passed by which in the textile, and later in the mining and other industries, an attempt was made to protect women and children from the degradation and suffering due to overlong hours and insanitary conditions. The struggle has been a long one, and is not yet over. Fresh attempts are made on the introduction of every new industry to exploit the almost limitless field of female labour.

Very different was the position of the middle-class woman. Bit by bit as the home became less a place of production she felt her economic justification slipping away from her. Long before the middle of the nineteenth century the position of the unmarried girl of the upper and middle classes was one of parasitism. The emptiness of their lives passed belief. Officially supposed to be "helping mother," they were forced to fritter away their existences in needlework, Italian, singing lessons, and inane social duties, waiting while hope and youth receded from them, till they should find a husband and "settle down" to the duties of a home of their own. Exploitation brings great suffering, but the need for human contacts and the realisation of utter and incomprehensible uselessness brings suffering as great though more obscure. Readers will remember the repinings of poor Caroline Helston in Charlotte Brontë's "Shirley," and much of the tragedy of the unwanted woman has found its way into Victorian literature. Indeed, it was from this class, women who had waited until middle life for the chance of marriage, that the pioneers of the feminist movement came. It was, on the whole, a demand of elderly unmarried women for the right to freer activities as the alternative to an impracticable ideal of marriage and motherhood for every woman. It is not surprising that the tendency was to overlook sexual differences, or rather to set sex entirely aside, since marriage was regarded as impossible.

There was no idea, as now, of a woman fitting herself for a profession which could be continued in spite of marriage. These early pioneers knew well that marriage was far from being the certainty or the likelihood that their opponents always assumed it to be. The alternative for them was not work *or* marriage, but work *or* a life of cloistered seclusion in their fathers' houses. It is evident, therefore, that their attitude was radically different from that of their working sisters. The labourer's wife and daughter had always been accustomed to a life of toil, which did not preclude, but was only modified by marriage. That of the middle-class woman was a result of the inevitable surplus of women, for whom the chances of marriages were virtually non-existent. To-day, as statistics show, the percentage of celibate men and women is far higher in urban districts occupied by the upper classes, since for the working man the question "Can I afford to marry?" does not present itself in anything like the same acuteness as it does to the individual of moderate means. The wife of the former is, as she has always been, the working partner of her husband, and if not definitely a source of income, justifies her existence in a thousand ways.

The war, then, did not affect the industrial married classes in anything like the same way as the middle and lower middle-class households. For the former, one may say, without lending undue credence to the rumours of pianolas and silk teagowns, that never have they been so well clad and so well fed as during the last fifteen months. The departure of the husband meant one less—and that the most costly—mouth to feed, together with an assured and graduated income, adequately proportioned to the needs of the family and the district, rural or urban, in which they lived. But for the bulk of middle-class households the poignant "what shall we do with our girls" problem began to have a very real importance. Apart from the rather hysterical and spasmodic desire to "do something," of which those of us who had any connection with the Red Cross during the first few months of hostilities saw a good deal, there came a gradual realisation that now, if ever, was the time for women, married and unmarried to justify their claim to be placed on the same economic level as men. The gradual weeding out of the men who could be spared from the "indispensables" has led to a demand for women clerks, secretaries, and accountants, to name three of numberless branches, where from all accounts the work of women is found to be of the same value as that of their brothers. I have before me the report of a committee appointed by Sir John Simon, when at the Home Office, to consider "what steps should be taken, by the employment of women or otherwise, to replace men withdrawn for service with the military forces." A Government White Paper does not, as a rule, make entertaining reading, but this one contains a few passages of quite exceptional interest. After discussing the possibility of employing (1) women already trained, but unemployed; (2) discharged soldiers and sailors; and (3) lads under military age to replace those of the vast army of 300,000 clerks who have

already joined or wish to join the colours, the committe report they "are satisfied that the bulk of the substitutes must be drawn from the ranks of *women not at present employed*, *women of intelligence* will be required to fill openings of a kind involving a considerable degree of responsibility. We recommend that every effort should be made to attract this class of woman into the work." But the report goes on to say—and this is the crux of the matter—"We hope it will be made clear that the employment of the women who are brought in to act as substitutes during the present emergency is intended to be *temporary*, for the period of the war only," the injustice of which is little mitigated by the modest suggestion that "in the present emergency the scale of wages to women should, as far as conditions permit, and as the work deputed to them reasonably justifies, be *based* on the rate of wages paid to men who have been engaged in similar duties." It is not surprising that Sir John Simon had to admit in the House that as yet the supply of middle-class women for these clerical posts was far from adequate. What less likely than that women of education and settled lives should be willing to undergo the expense of a special course of commercial training in order to fit themselves for posts that are so manifestly of a temporary nature.

And this brings us to one of the most important post-war problems with which we shall have to deal. If, as seems likely, before we have brought the present conflict to a victorious close, the aid of every woman in this country will be needed to carry on our industries, aiding our forces in the field, in a far more tangible way than knitting "comforts" and rolling bandages, what adequate recompense are we going to make when things resume once more a normal aspect. Not only will there be many young widows, but a considerably larger proportion of the girls of the rising generation than of the young women of to-day will be not only fatherless and brotherless, but husbandless and childless. Are the girls of the upper and middle class to continue to grow up work-shy and unskilled? Is employment to be open to them and to the daughters of the manual workers only in certain limited directions? Is it to be confined to the lower grades of trade industry? Are the wages of women always to remain inadequate to their needs? It is difficult—well nigh impossible—to say. But everything seems to point to an awakening in the spiritual consciousness of women. And there is a tendency, as yet ill-defined but none the less present, for women to divide into two sections—woman, the worker, and woman, the mother. Certain it is that a footing thus hardly won in the ranks of professionalism will not readily be relinquished. One foresees a stern and bitter conflict, resulting perhaps in this division of function at which I have already hinted, more probably in some temporary form of compromise. Sooner or later, however, the question will have to be decided, is it to be Love or economic independence, or *both?* Will the tenure of posts requiring skill and training by women be on the understanding that they are to be resigned upon marriage, or when the conditions of the labour market show they can as adequately be filled by men? Or shall we, on the other hand, see every woman faced at the outset of life with the momentous decision: is my life to be one of motherhood or active social service? I incline to think we shall. But here I touch upon a question which I hope to treat at some length in an ensuing article.

G. H. F. G.

Nursing News.

We are pleased to record that Miss C. A. T. McKay, T.F.N.S., Matron of the 4th South General Hospital, Plymouth, has been awarded the Royal Red Cross Decoration of the 1st Class; and Miss M. J. L. Lyons, Q.A.I.M.N.R., has been awarded the Royal Red Cross Decoration of the 2nd Class.

Miss McKay was trained at Guy's from 1903 to 1906, and, previous to taking up her duties at the 4th South General Hospital, held the appointments of County Superintendent of Nurses under the Q.V.J.I., and Inspector of Midwives under the Cornwall County Council.

Miss Lyons was Probationer at the Evelina Hospital for Children from 1900 to 1904, and entered Guy's in 1905. On completion of her training she was appointed Sister-in-Charge of the Out-Patient Department, and was afterwards transferred to Sister-in-Charge of Mary Ward.

Mentioned in Despatches.

Miss E. C. Cheetham, Acting Matron, Q.A.I.M.N.S.—Miss Cheetham was trained at Guy's from 1896 to 1899, and saw service in the Boer War. She holds the South African War Medals.

Miss G. E. Custance, Q.A.I.M.N.R.—Miss Custance was trained at Guy's from 1897 to 1900, and held the post of Nursing Sister at the Refugee Camp at Brandfort, and Matron of the Refugee Camp at Kimberley, O.R.C., from November, 1901, to September, 1902.

Mrs. Ethel F. Watkins, née Haggis, Q.A.I.M.N.S.R.—Mrs. Watkins was trained at Guy's from 1903 to 1906. On completion of her training she was appointed Matron of the Children's Convalescent Home, Gringley-on-the-Hill, Doncaster, and she has since been nursing in Nariobi.

Miss Evelyn J. Densham, British Red Cross Society.—Miss Densham entered Guy's as a Probationer in February, 1901. On completion of her training in 1904 she went to Cairo for a short time, and returned to Guy's the following year to take up the appointment of Sister-in-Charge of Queen Victoria Ward. She was afterwards transferred to the Clinical Wards, and from 1910 to 1912 held the post of Assistant Matron.

Ward Concert.

On Thursday, December 29th, a concert was given in Bright Ward by Miss Cecilia de Coverly's Concert Party, which appeared to be very much appreciated.

The ward was beautifully decorated for the occasion, this work of the sister and nurses adding much charm to the event.

Miss Guen. Webb Bowen very charmingly rendered the opening numbers, "The sunshine of your smile," and "Bird of love divine," followed by Miss Doris Pakeman, whose singing of "I wonder if love is a dream" and the "Fairy Flute" was so acceptable that two encores had to be given. Mr. Alec Price, who possesses a rich baritone voice, sang "The Floral Dance" and "Friend o' Mine" so pleasingly that he had to give several numbers. Miss Cecilia de Coverly then sang "The Spring's Awakening" and "Wake up," followed by Mr. C. Reynolds, whose racy telling of Short Stories sent the audience into a merry mood.

Miss Eileen Durham pleased the audience by her rendering of "Annie Lawrie," as did Nurse Smith, whose violin solos gave a welcome instrumental variety to the concert.

The grand finale of the concert was a costume performance of the "Passing Show," the characters being borne by the Misses Doris Pakeman and Eileen Durham, Mr. Alec Price and Mons. Liomin.

Miss May Lines at the piano proved a really helpful accompanist.

The performers very much appreciated the tea which was provided for them by the staff of the ward.

Abstract of Summary of Anæsthetics and Operations for the Year 1915.

THE number of cases in which general anæsthetics were administered was 7,690, among which were 69 intratracheal insufflations of ether, and 1 of C.E. Spinal anæsthesia was also employed on 43 occasions, and on 62 occasions spinal analgesia followed by a general anæsthetic. The total number of operations was 7,385 in Wards (Bright Ward excepted), Special Departments, Out-Patient Departments, and Surgeries. There was one case of a death under anæsthesia roported to the Coroner, particulars of which are furnished in the Appendix.

There have been 6,700 cases of general anæsthesia in the Dental Department; 6,340 under Nitrous Oxide Gas, 348 under Ethyl Chloride, 11 under Ether, and 1 under A.C.E.

Operations done on the medical side are entered under the assistant surgeons corresponding to the physicians or assistant physicians in charge of the wards, the table below showing how many operations are actually performed in these wards:—

ANÆSTHETICS.

A.C.E.	362
C.E.	1,395
Chloroform	804
Ether (including Gas and Ether)	1,107
Gas, and Gas and Oxygen	1,452
Intratracheal Insufflation of Ether	69
Intratracheal Insufflation of C.E.	1
Spinal Analgesia	43
Spinal Analgesia followed by a General Anæsthetic	62
Other Anæsthetics and Sequences	2,438
	7,733

ADMINISTRATION OF ANÆSTHETICS.

Staff Anæsthetists	1,997
Visiting Staff	249
Resident Surgical Officer	118
House Officers	4,896
Other Qualified Men	473
	7,733

OPERATIONS.—TABULATED ACCORDING TO WARDS AND DEPARTMENTS.

Astley Cooper	309	Addison	50
Cornelius	250	Mary	21
Lazarus	256	Stephen (Officers' Section	173
Job	408		
Naaman	317	Esther	40
Luke	293	Queen Victoria	451
Patience and Samaritan	522	Clinical	27
		Isolation	12
Evelyn	426	Out-Patients	1,544
Charity	326	Front Surgery	367
Dorcas	328	Back Surgery	63
Lydia	290	Light Department	3
Martha	332		
Eye Wards	577		7,385

Turning to the General Wards, it may be noted that the totals of operations are as follows:—

Surgeons	956
Assistant Surgeons	1,112
Specialists	89
Resident Surgical Officer	791
House-Surgeons and Assistant House-Surgeons	618
Dressers	611
	4,177

The remaining 31 operations, bringing the total up to 4,208, were performed by other operators.

It should, of course, be remembered that all operations in wards by Dressers and Resident Staff are performed under the supervision of the Resident Surgical Officer or of the Surgeon-in-Charge, and that no account is taken of operations done either under local anæsthetics or without anæsthetics at all.

Operations in the Obstetric Department (Queen Victoria and Patience wards) number 493, of which 240 were performed by the Obstetric Surgeons, 6 by the Resident Surgical Officer, 103 by the Obstetric Assistant, 121 by the Obstetric Residents, and 12 by Dressers, while 11 operations were performed by other operators.

The operations upon ophthalmic cases in the wards number 163, of which three were done by Ophthalmic Dressers, 13 by the Ophthalmic House-Surgeon, 7 by the Ophthalmic Assistants, 135 by the Ophthalmic Surgeons, and 5 by other operators.

There were 465 operations for Throat and Ear Diseases in the Wards; 373 by Surgeons, 4 by the Resident Surgical Officer, 22 by the House-Surgeon, 15 by Clinical Assistants, 32 by Dressers, and 19 by other operators.

In the Orthopædic In-Patient Department 36 operations were performed by the Surgeon of the Department.

In the Genito-Urinary Department 43 Ward Operations were performed, 25 by the Surgeon, 11 by the Resident Surgical Officer, and 7 by Dressers.

In the Front and Back Surgery 430 operations were performed, 8 by the Resident Surgical Officer, 70 by House-Surgeons or Out-Patient Officers, 349 by Dressers, and 3 by other operators.

In the General Out-Patient Department 400 operations were performed; 2 by Surgeons, 3 by Resident Surgical Officer, 26 by House-Surgeons, 329 by Dressers, and 40 by other operators.

In the Special Out-Patient Departments 1 operation was performed upon an Eye case: 1 for an Obstetric case; 973 upon Throat and Ear cases, of which 85 were by the Surgeon, 159 by the Clinical Assistant, 723 by Dressers, and 6 by other operators; 169 in the Orthopædic Department, 118 by the Surgeon, 2 by the Clinical Assistant, 42 by Dressers, and 7 by other operators, and in the Light Department 3 operations were performed.

APPENDIX.

Emma L., æt. 16, was sent to the Hospital by a General Practitioner on August 13th, 1915, and was admitted into Dorcas Ward under Mr. Dunn. She had been ill for five days, and on admission a pelvic abscess due to acute appendicitis was diagnosed. She was extremely ill and profoundly toxic. The R. S. O. operated the same evening. A large pelvic abscess and a gangrenous appendix were found. The appendix was removed and the abscess drained. The patient took the anæsthetic, which was administered by an A. H. S., very badly from the start. Her breathing was very shallow and her colour bad; her pulse was fair, considering her condition. Continuous axillary saline infusion was given, and the operation carried out with all possible speed. About 5ozs. of Ether and 30mm. of Chloroform were used. As the abdomen was about to be closed, the patient collapsed, respiration ceased, and the pulse could not be felt. Aritificial respiration was started, pituitary extract was injected into the heart, hot fomentations were applied to the præcordial region, the heart was massaged through the diaphragm, and oxygen was administered freely. Artificial respiration was kept up for twenty minutes, but without success.

Dr. Trevor, the Home Office Expert, was appointed by the Coroner, Dr. F. J. Waldo, to perform a post-mortem examination.

Local suppurative peritonitis was found in the right iliac fossa and pelvis, which contained a large abscess, and there were signs of early general peritonitis. The Fallopian tubes had pus in them. All the abdominal organs were much congested. The spleen was soft and friable. The kidneys were engorged but healthy. The veins on the posterior abdominal wall were distended with blood, but they contained no ante-mortem clot. The pericardium contained a slight excess of fluid. The heart valves were healthy. The cavities of the heart were dilated. The heart muscle was flabby and very friable, while signs of fatty degeneration were found in the musculi papillares. The lungs were congested. There was no pulmonary embolism. The brain was healthy. The tonsils were large, but there were no other signs of lymphatism.

Dr. Trevor considered that death was due to heart failure, following an acute toxæmia due to the condition found in the abdomen. He said that in such cases it was impossible to exclude the anæsthetic, that it was adding another poison to a system already overcharged with poisons produced by a natural disease; but that it was a justifiable procedure to administer such a poison in order to perform an absolutely necessary operation in an endeavour to save life. He was of the opinion that ether was the safest anæsthetic to use in such cases.

The Coroner's jury returned a verdict, in accordance with the medical evidence, that "death was due to misadventure."

Notice.

Royal College of Surgeons of England.

COURSE OF LECTURES ON THE ANATOMY OF THE BODY FOR FIRST-AID AND AMBULANCE STUDENTS.

A Course of Lectures will be given in the Theatre of the College, Lincoln's Inn Fields, by Professor Arthur Keith, Conservator of the Museum, at 5.30 p.m. on the undermentioned dates:—February: Mondays, 14th and 21st; Wednesdays, 16th and 23rd; Fridays, 18th and 25th. March: Mondays, 13th, 20th and 27th; Wednesdays, 15th, 22nd and 29th; Fridays, 17th, 24th and 31st. April: Mondays, 3rd and 10th; Wednesdays, 5th, 12th and 26th; Fridays, 7th, 14th and 28th. May: Wednesday, 3rd; Friday, 5th.

The course is open to all members of ambulance companies and of first-aid classes. A detailed syllabus of the subjects to be dealt with in each lecture will be issued at the commencement of the course. Anatomical preparations and specimens will be on exhibition in the Theatre from 4 to 7 p.m. on lecture days.

S. FORREST COWELL,
Secretary.

Honours.

For services rendered in connexion with military operations in the field:—

To be C.M.G.: Col. (temp.) Atkins, A.M.S.; Col. G. T. Rawnsley, A.M.S.

For distinguished conduct in the field:—

To be Brevet-Major: Capt. R. C. Ozanne, R.A.M.C. (S.R.).

Awarded the Military Cross: Temporary Capt. H. C. Godding, R.A.M.C.

Appointments.

Royal Army Medical Service.

The following appointments have been notified:—William Taylor has been entered for temporary service in H.M. Fleet; C. Warner has been appointed to the *Victory* for disposal.

Royal Army Medical Corps.

H. W. Bruce to be temporary Major whilst employed at the Southwark Military Hospital.

The undermentioned temporary Lieutenants to be temporary Captains:—C. H. Mills, T. J. Bennett, A. L. George, H. Wacher, D. W. Jones, E. Evans, H. C. Godding, A. G. G. Plumley, E. C. Myott, H. H. Carter, G. Scholfield (late Captain Hampshire Regiment Volunteers).

The undermentioned to be temporary Lieutenants:—J. Cameron, H. Harrison, G. Thomson, W. Wilson.

The undermentioned temporary Lieutenants relinquish their Commissions:—J. E. Barnes, C. C. Holman, A. R. Wilson, H. E. H Tracey, G. R. Phillips.

Territorial Force, R.A.M.C.

North Midland Casualty Clearing Station:—S. J. Kearney to be Lieutenant,

Northern General Hospital:—Captain G. S. Simpson is seconded whilst holding a temporary Commission in the R.A.M.C.

London (City of London) Sanitary Company:—A. Reid to be Lieutenant.

Canadian Army Medical Council.

G. H. Drake to be temporary Lieutenant.

Indian Medical Council.

Major J. H. Robinson, R.A.M.C., has been appointed Deputy Assistant-Director of the Medical Services (Mobilisation) of the 2nd Rawal Pindi Division.

Papers by Guy's Men.

Ralph Thompson, Ch.M., F.R.C.S.: Traumatic Stricture of the male urethra.—*Clinical Journal*, January 12th, 1916.

Ralph Thompson, Ch.M., F.R.C.S.: A case of hæmaturia.—*The Practitioner*, December, 1915.

Lawrie, McGavin, F.R.C.S.: Cancer of the penis.—*Clinical Journal*, January 19th, 1916.

A. S. Blundell Bankart, M.S.: Case of myositis.—*Proceedings of the Royal Society of Medicine*, December, 1915.

Capt. A. W. Ormond, F.R.C.S.: Associated jaw and lid movement.—*Ibid.*

W. Sampson Handley, M.D., F.R.C.S.: Ileus duplex (inflammatory enterocolic ileus).—*British Journal of Surgery*, October, 1915.

Reviews, etc.

Diseases of the Throat, Nose, and Ear. By W. H. Kelson. (Messrs. Henry Frowde and Hodder & Stoughton.) Price 8s. 6d. net.

A most concise and practical description of all clinical conditions falling within its scope, this book will be valued alike by the practitioner and student. The diagrams and plates are excellent and especially valuable will be found those demonstrating the methods and instruments applicable to the work. All the more usual procedures and conditions are most accurately described and set before the reader in such a way as to provide at once a book for either reference or systematic reading. Points which especially impress us are the description of X-ray appearances, the plates in colour of several essential observation areas and the very practical appendix on general therapy and prescriptions. The volume is excellently produced, and makes excellent reading to any interested in the fields of medical work under consideration.

First Aid to the Sick and Injured. An advanced ambulance handbook by F. J. Warwick and A. C. Tunstall. Ninth edition, revised. (Messrs. Simpkin, Marshall, Hamilton, Kent & Co., Ltd.)

The revised edition of this valuable little work contains descriptions of the appliances and procedures adopted in the early treatment of practically all cases likely to be met with in military or civil ambulance work. The reasons and causes of all conditions are efficiently noted. The whole is set down in a concise manner, making immediate reference easy, while the details and diagrams of drill, orderly, and field work cannot fail to be of use to any taking part in casualty or field medical work, no matter what their relative standing in the organisation. The book is of such size as to be readily carried in the pocket, and is extremely light in weight.

Infectious Disease in Serbia. By J. Furse McMillan. (Messrs. Baillière, Tindall & Cox.) Price 6d.

Though this little book comprises but sixteen pages, they are pages replete with interest and information for any whose medical duties carry them to the near East. Largely a recital of personal experiences, the little work gives an excellent idea of work in this troubled area, while the Serbian medical terms given in the last paragraph might prove of distinct usefulness.

A Manual of Surgical Anatomy. By Lewis Beesly and T. B. Johnston. (Published by Messrs. Henry Frowde and Hodder & Stoughton, at the Oxford University Press.) Price 12s. 6d. nett. First edition.

Surgical anatomy is a subject so vast that, perhaps, the greatest difficulty of an author is the limitation of his observations. This difficulty is, in a great measure, accomplished by Messrs. Beesly and Johnston in their new manual of surgical anatomy.

The authors are graduates of the Edinburgh school of surgery, and they present the latest teachings of that school. The method of teaching is excellent: first a portion of anatomy is described in some detail and this is followed by a concise account of the surgery concerning the part. Special mention is made of the ossification of bones, and the relations of the epiphyses to the capsules and synovial reflections of joints.

Descriptions of amputations of limbs are omitted. This rather spoils the completeness of the manual, but enables the volume to be of a comfortable size. The illustrations are numerous and are well executed; many of the purely anatomical illustrations are borrowed from "Cunningham's Manual of Practical Anatomy." Some excellent radiograms, the work of Dr. Edmund Price, give valuable information of the relations of osseus tissue in joints. We would recommend this volume to the notice of men in the dissecting room and to men who wish to read concise anatomy concerning surgery.

Rugby Football.

GUY'S v. MOTOR MACHINE GUN SERVICE (BISLEY).

This match was played at Richmond on January 15th. We had great difficulty in getting a XV. together owing to the number of scratchings, but by sticking to the match and practically refusing to scratch it, a side at length was obtained. These gunners were the toughest team we have met so far, and very unfortunately we were at our weakest when we met them. One does not say so because we were beaten, a glance at the side will show that sufficiently. Opposite us we had a Canadian player in Lieutenant Cowan who was quite first-rate, and the rest of the team were splendidly fit.

Clewer played on the wing as, since Blacklaw's injury, we are hard up for three's, and he brought off a good tackle quite early which prevented Williams getting in against us. Cowan dribbled on, but defence held, and a high punt sent the game well down field when Whitcombe gained possession with almost a clear run, which he did not take advantage of. Curle was excelent hereabout, running very strongly, and eventually play settled in the Gunners' 25 and a scrum took place beneath the goal post. The ball came out our side and Wade, alas, missed a rare chance; instead of passing he tried a feeble drop. Directly afterwards the ball was rushed to the other end whereMcLachlan scored an unconverted try, to be followed by another from Naylor almost at once.

After half-time we got the worst of it for some time; the forwards on our side played very well, but the halves could do nothing and the three-quarters failed to support Curle. Leviseur and McEvedy tackled well, but McEvedy was wrong to let himself be tackled in possession as the game was going against us and we wanted distance badly. Instead, play settled well in our half and Williams dropped a good goal which made us ten points down. Just previous to the final whistle Kidman got a try, and Reitz converting, the score against us was reduced to 10-5, or 1 dropped goal 2 tries to 1 goal—10 points to 5. Team :—

P. J. McEvedy (back); E. H. Clewer, F. W. Reitz, E. A. Leviseur, C. L. Curle (three-quarters); —. Wade, T. E. Micklem (halves); G. E. Kidman, D. M. P. Whitcombe, E. A. Phillips, J. C. Gie, C. Calvert, A. W. W. Armstrong, J. Shellswell, A. N. Other (forwards).

GUY'S v. A.S.C. (M.T.) DEPOT, GROVE PARK.

Most past and many present Guy's men remember Mr. R. V. Stanley, of Oxford University, popularly called "Uncle," who for many years has been to our ground with the Oxford team, and who is a member of the International Selection Committee. This Grove Park team is largely the result of Mr., now Captain, Stanley's enthusiasm for the game. The side had many men of high reputation, for instance, the three-quarters were Captain Nixon, Lieutenant Duggan, Private Corsi, and Lieutenant Hennessy. The two outsides were Nixon and Hennessy, most determined runners. Duggan is the old London Irish and Richmond player: Corsi was a Welsh School Boy International and has recently played Northern Union with Huddersfield. Clarke, among the forwards, is a Northern Union International. He is a great player, and he plays the game perfectly as it should be played. The exhibition he gave on Saturday, January 22nd, was worth going to see as a sample of good football played as a sportsman whose skill and reputation are too great to be sullied by the least questionable tactic.

Knott and Kendall having cried off, Whitcombe came in forward for Reitz, and Harrington stepped in to complete the side. If Harrington did not run across so much he would be very useful. The soldiers were very vigorous, and we were frequently almost brushed aside by their impetuosity, but we scored first, Curle following up a lofty cross kick from Medlock. Becker mixed things up afterwards by erratic passing, and our opponents got on to the ball and a try at once. The place was straight in front of the bar, but luckily for us Hennessy missed. Then Clarke got a try which Corsi converted, and our men were so blown at half time that things did not look very promising. However, with the wind they stuck to their task, though it looked bad for us, as their rushes were most difficult to stop. Reitz took a penalty from far out splendidly and brought our score up to 6 points. Then a cross kick found Curle well up again, but the bounce went wrong, and not until just on time did an unconverted try by Armstrong put us just one point ahead and by that margin Guy's won. Guy's, 1 penalty 2 tries, 9 points; A.S.C., 1 goal 1 try, 8 points.

J. Forbes (back); F. J. Harrington, F. W. Reitz, E. A. Leviseur, C. L. Curle (three-quarters); C. C. Becker, C. H. Medlock (halves); G. E. Kidman, C. W. W. Armstrong, J. C. Gie, A. W. A. Davies, D. W. P. Whitcombe, J. Shellswell, E. H. Clewer, E. A. Phillips (forwards).

Birth.

DAW.—On the 20th inst., at Clarendon Road, Leeds, the wife of S. W. P. Daw, F.R.C.S., Capt. R.A.M.C. (T.F.), of a son.

Marriage.

COFFIN—STUART-MURRAY.—On January 10th, 1916, at the Church of St. Jude-on-the-Hill, Hampstead Garden Suburb, by the Rev. Basil Bouchier, C.F., Lieutenant Stephen W. Coffin, R.A.M.C., son of Harold W. Coffin, to Iris, only daughter of the late Frank Stuart-Murray.

F. A. K.

GUY'S HOSPITAL GAZETTE.

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Passim.

AS our last number appeared, the finale of the Christmas functions was in full swing, and we most heartily congratulate the Residents on their two concerts. In consideration of the time at their disposal—little over three weeks in fact—truly astonishing results were obtained.

We feel sure that all who helped to form those enthusiastic audiences in the physiological theatre will join us in hearty votes of thanks and success.

The programme and reports of the evenings appear later in this issue, and we hope that these inadequate words of appreciation will reach each of those "Minims" and their willing assistants at no very distant time.

WELL advanced as the New Year now finds itself, little or none of the Governmental guidance has apparently found its way to our slowly diminishing community. Without doubt the policy of obscurity and vagueness is working wonders in our national preparations, and all are being led unconsciously in the path where the need is greatest, but we cannot always close our ears to the argument and discussion which these days have brought amongst us, and in view of such daily, almost hourly, happenings we would venture to express an opinion that action and policy should be guided by advice so kindly given through the medium of the President of the Residents on his recent visit to the Office. We hear that the local authorities to be found at the Southwark Town Hall can give more definition and direction than most of us have hitherto imagined, and we suggest that a personal visit is well worth while from all points of view.

RECENTLY we have received a number of requests for lists of Guy's men on active service, lists of honours, and the like. We would take this opportunity of pointing out that such lists are being compiled gradually by the Will's Librarian according as the news reaches us, but, firstly, as such records are of necessity at present incomplete, and secondly, as the publication of such a temporary list some months ago brought so fierce a storm of criticism from those of whose doings we had been in ignorance, we feel obliged to refrain from putting into print the mass of details in spite of the pride which we feel at even their present dimensions.

MAY we even once again appeal to men on active service for letters to the GAZETTE? We imagine, though perhaps quite wrongly, that many have times of inactivity and repose, and it is a few of these precious moments we would so selfishly claim. Many have told us their news: perhaps they will break from their silence again and help to hold together the comradeship of former days.

PROBABLY it will be thought that we are again short of material to keep the tint of these few pages less pallid than that of snowy whiteness—probably the casual thinker will be unusually correct; and so our own musings follow in lines hardly parallel but at least similar to those which prompted the penning of the following in the "Editorial" of a certain American journal some short while ago:—

"It is reported that one of the fastidious newly-married ladies in this town kneads bread with her gloves on. This incident may be peculiar, but there are others. The editor of this paper needs bread with his shoes on, needs bread with his shirt on, needs bread with his hat on, and unless some delinquent subscribers to this 'Old Rag of Freedom' pony up before long, he will need bread without a dashed thing on, and this town is no Garden of Eden in the winter time,"

AT a meeting of the GAZETTE Committee held on Thursday, January 27th, Mr. W. J. Curry was appointed Manager of the GAZETTE in place of Mr. C. H. Wells, retired, and Mr. F. A. Knott appointed Editor in succession to Mr. E. N. Glover, resigned.

Papers by Guy's Men.

Capt. A. W. Ormond, R.A.M.C.: The treatment of concussion blindness.—*Journal of the R.A.M.C.*, January, 1916.

Lieut.-Col. W. H. Ogilvie, I.M.S.; A case of probable spontaneous rupture of the spleen.—*The B.M.J.*, February 5th, 1916.

The Residents' Concert.

PROGRAMME, JANUARY, 1916.

PART I.

1 Introduction (*Low*).
2 Topical Ditty, "Smile, Smile, Smile" (*Asaf*).
3 Song, "The road that leads to home" (*Breville-Smith*).
4 Spring Song, "Twelve little girls per year" (*Darewski*).
5 Irish Song, "A little bit of Heaven" (*Brennan*).
6 Tragedy, "The only one the poor girl had" (*Finck*).
7 Chant, "Jenny my own true love" (*Osborne*).
8 Good Advice, "Keep it dark" (*Darewski*).
9 Patter Song, "My Dreams" (*Tosti*).
10 Coster Song, "Wouldn't it be loverly" (*Scott*).
11 Trio, "Cuthbert, Clarence, and Claude" (*Blake*).
12 Nautical Ballad, "The grey North Sea" (*Hewitt*).
13 Idyll, "Michigan" (*Berlin*).
14 Humoresque, "The other Department, please" (*Fragson*).
15 A Regret, "The High Cost of Loving" (*Meyer*).
16 Scenic Song, "Just we two and the Moon" (*Hirsch*).

PART II.

IMPROMPTU BURLESQUE

ENTITLED

"_____"

(Somewhere in Guy's),

BY THE

10 MINIMS OF STRYCHNINE.

PART III.

1 Song of the Times, "I do like living in England" (*Valentine*).
2 Lament, "Flower of Brittany" (*Löhr*).
3 Step Song, "At the Fox Trot Ball" (*Ayer*).
4 A Moral, "Tommy Didn't Care" (*Lublin*).
5 Conundrum, "Why did I f-foller her about" (*Trevor*).
6 A Rag, "The Wriggley Rag" (*David*).
7 Song, "They didn't believe me" (*Kern*).
8 Ditty, "Shop!!" (*Forman*).
9 Song, "The Rag Picker" (*Berlin*).
10 Ballad, "Drake Goes West" (*Sanderson*).
11 Hunting Song, "They follow me around" (*Berlin*).
12 Finale, "Peace" (*Darewski*).
"God save the King."

THIS year, as in the previous last two years, the Residents, on account of the war, gave a concert instead of the usual play. It was held in the Physiological Theatre on the 28th and 29th of January. The concert differed slightly this year from the previous years in that instead of being partly professional it was entirely local talent. It was a great success, and considering that it was all got up and arranged in three weeks, the performers are to be heartily congratulated. So well did the members of the troupe keep secret

what they were going to do, that it was not until the curtain went up that we discovered their design. When the curtain was raised on the first night we saw the 10 Minims of Strychnine, as pierrots, arranged in a semicircle, one wing white, the other black, the President, the central figure, in green, and Mr. Curle, the accompanist, in purple. All the members of the troupe were masked, and it was not until this disguise was removed by each man as he set out on his first song that we could decide on their identity. The stage was entirely black, and the lighting of the stage and the limelight (worked by Mr. Glover) showed the performers off with great effect.

Mr. Curle played some selections from "Bric-a-Brac" before the curtain was raised. The performance was started with an opening chorus, which was very good, and soon assured us that we were going to have an enjoyable evening. After this Mr. Eccles lead off with "Smile, smile, smile," and proved as popular as ever, and his other song, "I do like living in England," went down very well. Mr. Knott sang "A little bit of Heaven," and brought the house down, and should have got a well-merited encore, but, unfortunately time would not allow; his other two songs "Michigan" and "They didn't believe me" were also well received. Mr. Wilson kept the audience in roars during his three songs, perhaps the best being the coster song, "Wouldn't it be loverly?" and we are sorry that he has not come out of his shell before this year. "The grey North Sea," sung by Mr. Attwater, was very popular, and we can safely prophesy this becoming one of our National songs. Mr. Woodruff's three songs, "My Dreams," "The Other Department," and the "Wriggley Rag," almost made us think that he had come straight from the Empire, and we would not be surprised if we see him one day there taking Harry Tate's or Wilkie Bard's place. The trio, "Cuthbert, Clarence, and Claude," by Messrs. Kendall, Knott, and Woodruff, was excellent, and kept us laughing from beginning to end. Mr. Kendall sang "twelve little girls per year," and "They follow me around," and was very popular with the ladies, but from what we know of him we are sure that his first song showed him off in his true colours. He is to be congratulated on them considering that he had been laid up with a cold for four days before. Mr. Holmes' "Breach of Promise" song was highly amusing and very well done. The President told us that he found loving rather expensive; and his mannerisms in "The Rag Picker," kept us highly amused, and he proved as popular on the stage as off. "Just we two and the moon," by Mr. Medlock, with the scenic effect of having the theatre in darkness and the faces lit up by electric torches was very pretty and got a good reception.

The second part of the programme was a short burlesque, the scene "suggesting" the colonnade in the early afternoon, and we saw the members of the Staff arriving. Mr. Wilson as Sir Arbuthnot was an excellent impersonation and splendidly acted, in fact, we hear that Lady Lane had fears for Sir Arbuthnot's coat, although we have it on the highest authority that it was not his. Mr. Holmes as Dr. Fawcett was true to life and excellent. As the old lady distributing tracts he almost outrivalled his nigger performance. We had fleeting glances of Drs. Beddard and French on their way through well done by Messrs. Knott and Curle. Mr. Kendall as Lord Knows Who inquiring for "Captain Damnit" in the officers section was splendid, and the answers to his inquiries brought the house down. He also took off Mr. Fagge with success, but as Sir Cooper he made the hit of the evening, and we were not sure that it was not the Superintendent himself. Messrs. Eccles, Woodruff, Attwater, and Dean, as the patients, kept up a flow of wit which greatly added to the success of the burlesque. Mr. Attwater as the Rev. Charlesworth made us think he had missed his vocation. The parts of the house officers, students, and loafers were taken by members of the troupe whenever not otherwise occupied. Mr. Medlock as the porter on the telephone was very realistic, and the whole performance was splendid and most popular. If we may be allowed to suggest, it is a pity we could not have been treated to more.

The Troupe must be congratulated on their performance and are to be thanked for a most enjoyable evening, in fact, we heard many of the audience saying that it was one of their happiest for years.

Mr. Tanner very kindly acted as stage manager. and his criticisms and suggestions greatly helped to the splendid success of the evening. Mr. R. Curle was, as usual, excellent at the piano. Messrs. Stallman and Burnside acted as ushers and held the doors stolidly. Mr. Forbes made an excellent Buttons, and we have also to thank Sisters Out-Patients, Astley Cooper, Addison, and Surgery for their assistance in the stage preparations.

Change of Address.

A. Leigh Allworth, West Hill Lodge, West Hill, Sydenham, S.E.

D. H. A. Galbraith, Essex Hospital, Colchester.

Capt. W. L. E. Reynolds, R.A.M.C., 56th Field Ambulance, 18th Division, B.E.F.

E. L. Martyn Lobb, M.S., F.R.C.S., West Kent General Hospital, Maidstone.

W. T. Chaning Pearce, No. 11 General Hospital, Boulogne.

Lieut. B. B. Gough, R.A.M.C., from Lahore General Hospital, Calais, to 51st Field Ambulance, 17th Division, B.E.F.

H. D. Shore, L.D.S., 4, Seymour Street, Portman Square, W.

Lieut. G. Covell, M.S., from No. 1 Ind. Gen. Hospital, to 139th Indian Field Ambulance, I.E.F. in East Africa, c/o India Office, London.

"The Ideal Nurse."

Ah, but whose ideal? What a diversity of opinion and judgement there could be on this subject. Is she the graceful and picturesque figure that adorns the pages of war-time illustrated papers, and appeals from the hoardings for your sympathy with her ministrations to the wounded hero, while impressing upon your memory the excellences of a certain cigarette! Or in contrast la Religieuse, austere, remote offering as a sacrifice her services to suffering humanity. "Our dress of black and white," said one, "tells others that we are creatures of strength and sympathy. At our bidding all tears are dried, and all who suffer come to us for consolation, but nobody thinks of our own suffering. We are like women without faces." The arts of medicine and nursing still await their special poet. Will he be found in this time of strife?

Rupert Brooke was too intent to achieve the adventur of death to consider those who would delay or ease the journey thereto. His concern was not with "the broken body that soon has ending."

As Henley lay for months in the old Edinburgh Infirmary, he pictures, not his ideal, but the nurses as they moved about him:—

> . . . "the night-nurse,
> Noiseless and strange,
> Her bull's-eye half-lanterned in apron (whispering
> me, 'Are ye no sleepin' yet?")
> Passes, list-slippered and peering,
> Round . . . and is gone."

The Old Style Nurse, of whom he says:—

> "The greater masters of the commonplace,
> Rembrandt and good Sir Walter—only these
> Could paint her all to you."

The Probationer—New Style:—

> "Dark eyes and shy that, ignorant of sin,
> Are yet acquainted, it would seem, with tears.;
> . . . and I remain
> Absorbed in her, as in a pleasant mystery.
> Quick, skilful, quiet, soft in speech and touch . . .
> 'Do you like nursing?' 'Yes, sir, very much.'
> Somehow, I rather think she has a history."

A London surgeon of to-day very fitly opens his course of Lectures to Probationers with a description of the woman he would choose to nurse his patients:—

"More inspired pens than mine have sketched the Ideal Nurse, but let me endeavour to depict her as I picture her. Trimness and tidiness in person and appearance predispose the patient in her favour. She is calm, serene, and cheerful; she has her worries, anxieties, and sorrows, like other people, but leaves them outside the sick-room, because her rôle is not to receive ympathy, but to give it. Her smile is an encouragement, and when she enters the room the patients feel better, and are sure that they will do well. She has the gift of sympathy, not of the wet-eyed, but of the tender and helpful sort; she knows the shrinking and dread of the nervous girl who has to undergo an examination, and of the nervous woman who has to face the ordeal of an operation; with its unknown but vividly imagined terrors, and its uncertainties of life and death. To her, this is not merely a 'case' to be scolded, treated abruptly, or dealt with in a manner of formal routine, but a woman to be cheered and encouraged, to be fortified and enabled to go through her ordeal with courage and hopefulness. She is quiet in her ways and movements, active without being fussy, reposeful without being lethargic. She talks but little; she is very reserved on the subject of the patient's illness or operation, and refers the patient and her friends to the doctor for all enquiries. She speaks seldom of her previous cases, and never of the bad ones, unless to draw lessons of encouragement; she is singularly reticent about her own affairs.

She is not small-minded, and she is incapable of a petty spite; she looks out on the world with a large-hearted tolerance for the opinions, and charity for the actions, of others—though in her own thoughts and life the sharp boundary lines of right and wrong are never blurred.

In her work she is tidy and methodical; she is quick, but thorough, not slapdash or slovenly. Her ministrations are marked by gentleness and delicacy, without prudery; she avoids hurting susceptibilities, but does not fail in efficiency. She is scrupulously exact in the carrying out of instructions, but she cares even more for their spirit than for their letter; and because she has a sound judgment she can be given some scope to exercise her discretion. She is watchful and observant; she can tell the surgeon all he wants to know about the progress of the case, and is quick to detect any signs that are unfavourable.

She has intelligence as well as judgment, and in order to increase her practical efficiency as well as her interest in her work, she has acquired some knowledge of the medical aspects of her subject, by reading about the diseases from which her patients are suffering. She is eager to learn and quick to understand, and she has a retentive memory.

She values and cares for her health, knowing that this is essential for her work; but when the occasion demands she can sacrifice personal comfort and convenience to devote herself whole-heartedly to the needs of her patients. No effort is too great for her: no detail is too small for her.

Does this sketch appear to be too idealized? It is nevertheless drawn from life."

For the comfort of those, who, after reading the foregoing, would cry with the psalmist of old, "I cannot attain unto it," the secret may be divulged that the excellences of *three* ordinary nurses, known to this surgeon compose his ideal!

S.

All Souls' Day in Manaos.

THE dead are not forgotten in Manáos, on All Souls' Day, at any rate, when the feast set apart as the occasion for praying for the repose of the souls of all deceased Christians is peculiarly honoured. Manáos is the capital of the State of Amazonas, Brazil, and the folk are early astir there, when the inhabitants try for a time to remind themselves that, after all, the grave is only one of life's incidents.

Soon after day-break, which on the equator always occurs within a few minutes of six o'clock, crowds wend their way to the various churches to assist at the requiem masses which are about to be celebrated. The stranger is struck by the absence of the usual gay colours from the costumes of the women. All are dressed in the deepest mourning, seeming just to have lost some dear relative. During the service the women of the congregation pray devoutly and listen with attention to a lacrymose sermon on the text: "It is a holy and wholesome thought to pray for the dead that they may be loosed from their sins." As the preacher grows eloquent the women weep. The men laugh. With the exception of two or three pious and aged pillars of the church who have seats in the sanctuary, they stand about in the aisles and at the foot of the church, talking, joking, and generally playing the fool. They exchange greetings; they discuss the latest scandal, arrange business matters, or comment loudly on the good looks of the girls present. From time to time comparative silence is broken by the wail of an infant. The unhappy child is immediately shaken to and fro by its irritated mother, and should this not have the desired effect (and it never has), the child is smacked with no gentle hand—and the lamentation is increased. At length, after alternately shaking, smacking, and kissing the infant, its mother takes a dirty bottle out of a still dirtier paper parcel and the crying stops in an instant.

After the requiem, the burial service is recited over a catafalque (allegorically representing all the faithful departed) raised in the middle of the nave. Then the folk troop back to their homes to make the final preparations for their trip to the cemetery of S. Joao, a plot of land about half a kilometre square at Moco, just outside the town. By 9.30 there is a steady stream of pilgrims to this last resting place of so many of their relatives and friends, and the tram service, though doubled, can hardly cope with the heavy traffic. The cars are driven at break-neck speed, and as soon as their passengers are discharged at the cemetery, they return to town as fast as they can with safety.

The sight at Moco is both picturesque and touching. Candles burn on nearly every grave in memory of the departed. Around the tombs families are encamped; some are absorbed in prayer; others are weeping; here a grave is being decked with wreaths, all of which bear little miniatures of the dead, and at the head there is a large portrait of the deceased surrounded by flowers and candles; there a handsome marble tomb is being unveiled in the presence of a large gathering of sorrowing relatives, and a still larger gathering of interested spectators. The tomb is a representation of the door of a house standing ajar. In the doorway a woman stands with two little boys clinging to her skirts and looking up into her face, a little baby is in her arms. An inscription gives the circumstances of her death and the names of the children.

In another part of the cemetery is the grave of Sr. Adolpho Fulano de Tal, a journalist who was murdered some few months ago. On the grave is a copy of a newspaper with an obituary notice containing a most flattering account of the virtues and accomplishments of the deceased, together with a description of how his brilliant career was cut short by villainous, heartless, ever-to-be-execrated José Sicrano, his valet, whose ingratitude, so the paper tells us, excels that of Brutus, the slayer of Julius Caesar. Framed photographs of the corpse as it was found and of the assassin are displayed, together with the blood-stained knife with which the deceased was stabbed, so as to excite the sympathy and arouse the anger of the spectators. Two or three sailors are seen decking a monument set up in memory of two of their number killed in a fight with the police. The inscription explains that "the heroes died in the endeavour to frustrate a gross abuse of authority by a tyrannous Governor." On making inquiries I discovered that they were killed while attempting to prevent the arrest of an intoxicated friend who had insulted the Governor at a public function. Wandering on I discover the graves of two Englishmen who have died within the last few months. These are not forgotten, for each bears a little bunch of common flowers and there are several candle stumps round them, offerings placed there before daylight by the Portuguese and Brazilian labourers who worked under the deceased.

Midway along the eastern boundary there is a wall about three feet high enclosing a rectangular pit, about twenty by thirty yards in area and twenty feet deep. This is the bone pit. Unless the freehold of the ground in which a corpse is buried has been purchased, it is disinterred after five years and cast into this pit, the bottom of which is covered with glistening bones and grinning skulls, bleached white in the strong tropical sun. Around the top of the wall burn lighted candles, and old men and women stand around lamenting the loss of their kindred whose bones lie in the pit.

Soon after eleven o'clock the luncheon baskets of the pilgrims are opened, and an appetising repast is

spread on the ground to cheer the drooping spirits of the mourners. The hawkers outside the gates do a roaring trade in greasy plates of "feijoada" (dried meat and beans stewed together), the national dish of Brazil, which they can hardly serve out quickly enough to the hungry mob. The fruit-drink and sugar-cane juice stalls have a good share of the trade and so have the two little "botequins" (cafés) opposite the great "reservatorio" (a huge cistern) at the north-eastern corner of the cemetery.

As the day wanes, the throng gets greater and greater and the tram-cars work at high pressure. By 5.30 the crowd is immense and is still further swelled by the arrival of clerks and business men. Every grave, as well as the bone pit, is surrounded by a ring of candles, some burning sadly in the bright sunlight, others, as yet unlit, awaiting the fall of night which comes down suddenly at six o'clock.

By ten minutes past six all the candles are alight, and from this time to midnight the vast graveyard is a fairy-land of twinkling lights. In the middle of the cemetery there is a monument, a cross on a rocky pedestal, erected to the memory of all "Amazonenses" who are not buried in their native city. Around this monument there are hundreds of candles, and every minute fresh ones are added to the little army, as it were, besieging it. At eight o'clock the heat round the cross is intense and the candles stuck to its base melt, the grease dropping to the ground. Dense volumes of black smoke curl upwards from the host of candles; suddenly, with a roar, the smoke ignites and the monument is converted into a bon-fire around which gather scores of little gamins who throw old candle-boxes, pieces of paper, bits of wood and other fuel to augment the merry pyre. Streams of molten wax flow over the ground, and hundreds of nocturnal insects buzz around the flames, "Poor souls in purgatory," say the uneducated Brazilians. The festival, which up to now has been one of mourning, becomes one of general merrymaking which continues till nearly midnight.

Soon after eleven o'clock the crowds begin to disperse, and a free fight rages round the homeward-bound tram-cars, which are filled to their utmost capacity. By 12.15 the graveyard is deserted, and only here and there can a dying candle be seen. At 12.30 all is darkness, and only the heavy smell of burnt wax remains to remind us that yesterday was All Souls' Day. In the morning comes an army of beggars to collect the grease which is sold to manufacturers in the town to be remade into candles for the feast of the Purification (Candlemas), and thus the last trace of the previous day's ceremonies is effaced.

NASCIDO CANSADO.

Appointments.

Royal Navy Medical Service.

E. J. Cooke, Milton Hall Section Hospital, Steventon, Berks, has been given a commission as temporary Surgeon, R.N., with seniority of January 4th.

Temporary Surgeon H. S. Brown has been appointed to Plymouth Hospital.

Royal Army Medical Corps.

The undermentioned Majors to be temporary Lieut.-Colonels whilst in command of field ambulances:—J. E. Powell, D. P. Watson, A. C. Osburn.

The undermentioned temporary Lieutenants to be temporary Captains:—J. E. Lauder, E. Shelton-Jones, J. W. Grice, J. B. German (late Surgeon, R.N.).

To be temporary Captains:—M. J. Rees, F. A. Bainbridge.

To be temporary Lieutenants:—J. B. Dunning, E. Evans, G. B. S. Soper, W. S. Lacey, H. W. Evans, E. R. Hart, F. D. Crew.

To be Honorary Lieutenants:—O. G. Morgan, W. Wilson, C. R. Lucas.

Territorial Force, R.A.M.C.

West Riding Field Ambulance: Lieut. T. J. Mills to be Captain.

London Casualty Clearing Station:—F. A. Dick to be Lieutenant.

London Field Ambulance:—Lieut. T. A. Townsend to be Captain,

East Lancashire Field Ambulance:—J. Young to be Lieutenant.

Attached to units other than medical units:—Lieut. A. G. Osborn to be Captain.

R.A.M.C.—Honours

Inspector-General Belgrave Ninnis, C.V.O., R.N., has been created a Knight of Justice of the Order of St. John of Jerusalem of England.

Temporary Colonel J. Atkins, M.B., F.R.C.S, who was lately mentioned in despatches, has received the Order of the C.M.G. for services rendered in connection with military operations in the Field.

Colonial Medical Service.

Mr. C. F. Watson, Provincial Medical Officer, Nigeria, Northern Provinces, has been promoted Deputy Principal Medical Officer, Gold Coast.

Civil.

R A. Greeves, M.B., B.S., has been appointed Assistant Surgeon to the Royal London Ophthalmic Hospital, Moorfields, E C.

E. L. Martin Lobb, M.B.,F.R.C.S., has been appointed Surgeon to the West Kent General Hospital, Maidstone.

An Apparatus for the administration of Warm Ether, Warm Chloroform or mixtures of the two.

BY FRANCIS E. SHIPWAY.

By kind permission of Editor of LANCET.

THE discovery of "open ether" in America was shortly followed by a recognition of the necessity of remedying the defects inherent in this method. Chief of these is the lowering of the temperature of the inhaled mixture of air and ether due to the coldness produced by the evaporation of ether and the tendency to the formation of frost on the mask. This lowering of temperature is progressive, and may continue until the inhaled vapour may be 30°—40° F. below the temperature of the room. Cunningham and Anderson, indeed, have stated that in a room at 80° F. with the "open" method a 2·1 per cent. ether vapour reduces the temperature of the inhalations to 30° F., a 5·4 per cent. vapour to 9° F. Evidence is adduced in this paper to show that the inhalation of a cold vapour, besides having other consequences, reduces the body temperature to an extent which may no doubt be of comparatively small importance in many surgical operations, but in a great number, and especially in unfavourable cases where any adverse factor is of moment, must lessen the patient's chances of recovery and may increase the risk of pulmonary complications.

It is, further, a practical disadvantage of the method that the saturation of the fabric and freezing of the moisture of the breath interfere with the free intake of anæsthetic and therefore with the smoothness of anæsthesia, and sometimes with a proper depth of anæsthesia.

Another disadvantage is the waste of ether, which can only be kept within reasonable limits after considerable experience. It is also an objection that the dispersion of the vapour into the room, especially if, as is often the case, the room is small, is a source of discomfort to those engaged in the operation.

Various devices have been used in order to remedy these defects, but they all suffer from the same fault, *i.e.*, that the chief advantage of the "open" method—the free interchange of air—is lost. The more nearly the anæsthesia approaches the "closed" type, the more it deteriorates in quality. The problem was attacked on scientific lines by Gwathmey,[1] who undertook a systematic investigation, clinical and experimental, with a view to determining the relative value of chloroform, ether, and nitrous oxide when administered cold and when administered at blood temperature. He found that these anæsthetics are much safer when administered at blood temperature, *e.g.*, whereas it took 6·57 minutes on the average to kill 16 animals with chloroform at room temperature, it took 20·35 minutes to kill 17 animals with warm chloroform. Similar results were obtained with nitrous oxide and oxygen, death occurring more quickly when the gases were administered at room temperature; the action of the heart and the respiration were also more irregular. Nitrous oxide and oxygen at a temperature of 33°-34° F. caused death in a much shorter time. Fewer experiments were made with ether, but enough to convince Gwathmey that warm ether vapour is twice as safe as cold. He concludes that all anæsthetics heated to the temperature of the blood are increased in value as regards life without their anæsthetic effects being decreased.

Gwathmey investigated also the effects of warm anæsthetics on the maintenance of body temperature, and his conclusions have been confirmed by Davis,[2] whose observations have a particular interest for the anæsthetist who uses "open ether." It has long been known from the researches of Kappeler, Allen, and others, that the temperature of the anæsthetised person falls, due chiefly to diminished oxidation and to the interference with the heat-regulating centres. The fall is greater in proportion as the operation is protracted, or large surfaces of the body are exposed, or the loss of blood is considerable, and may be of great importance in feeble, very young, or elderly patients, particularly if no special precautions have been taken to cover up all parts outside the operation area. Davis supports the work of the earlier investigators, and points out that the method of anæsthesia has more influence upon the maintenance of the body temperature than is commonly supposed to be the case. He found that in 140 patients anæsthetised by the "open" method there was an average loss of temperature of 1·02° F., as against an average loss of 0·29°F. in 26 patients anæsthetised by warm vapour; the temperature was taken by the rectum immediately before and after anæsthesia. In 5 cases in which a large surface of the body was exposed, the anæsthetic being "open ether," the average loss was 1·98° F.; in 6 cases under similar condi-

tions, except that a warm vapour was given, the average loss was 0·77° F. There was a loss of 2·99° F. after appendicectomy and removal of one ovary in a patient who during 1½ hours lay on a cold table, the abdomen having been flushed with fluids and covered with wet towels; these conditions are to be found less frequently to-day, but they still occur on a smaller scale in a certain number of abdominal and other severe operations. It is, therefore, a good plan to change towels which have become wet with saline or lotion during a protracted operation, for if allowed to remain they have the same evil effect as the towels wrung out of antiseptic which were formerly used to surround the area of operation. These results of Davis are important, and he concludes from these observations and from experiments on animals that warming of ether vapour before inhalation will prevent loss of body temperature, or may actually increase the body temperature in a degree proportionate to the temperature of the vapour and also to that of the operating room. Undue elevation of the temperature from this source is injurious. With regard to the effect of morphine, he states that the previous administration of this drug does not greatly increase the loss of body temperature caused by ether. Excessive application of heat to an individual under morphine will lessen the usual loss of heat; the additional administration of ether in these circumstances may lead to a rise in body temperature rather than to the expected fall.

In close connection with this subject is the question of the optimum temperature of the operating room; Davis favours a temperature of 80° F. or over, showing, as is only to be expected, that the higher the temperature the less is the loss of body heat. It is doubtful, however, whether his view will be generally accepted. High room temperatures lead to sweating and exhaustion, not only of those taking part in the operation—a matter of some importance in hospital work with a lengthy list of operations—but of the patient. Sweating is particularly harmful to the patient, both because he loses fluid and because he is chilled by contact with wet garments.

Of even more importance are the effects of warm moist atmospheres on the efficiency of those working in them. Dr. M. S. Pembrey (Journal of Physiology, vol. xliii.) has shown that the tendency of these atmospheres is to throw a tax upon the powers of accommodation as indicated by the low blood-pressure notwithstanding the rapid rate of the pulse. This applies equally to the patient who has to do increased work at a time when his powers of resistance are being lowered by the surgical procedure. The most rational plan seems to be to maintain a dry temperature of 65°-70° F., to keep the patient warm, the theatre well ventilated, and to use warm anæsthetic vapours. Dastre stated that the body temperature falls more rapidly with ether than with chloroform, but Davis finds that chloroform produces a loss of body heat approximately equal to that of ether.

The simplest method of administering warm anæsthetics is the "warm vapour" method, by which is meant a system which applies to ether and to mixtures the principle of Junker's inhaler, with the addition that the vapour is warmed and is of suitable concentration to be used in general surgery. It is, when applied to ether, an "open" method in which the patient breathes *from* an atmosphere of warm ether vapour and air instead of inhaling cold vapour *through* a fabric. It preserves the best points of "open ether," viz., simplicity, free respiratory exchange, and equable dosage. It is economical of ether, since the patient receives at each inspiration a suitably adjusted and practically constant percentage; no ether is lost by evaporation and very little during expiration. It solves partially for those anæsthetists who do not use intratracheal insufflation the difficulties of anæsthesia in patients lying in awkward positions. Further, it enables the anæsthetist to be more out of the way of the surgeon and to be less hampered in his work than when he is using a drop bottle.

In addition to these advantages, warm vapours are more pleasant to inhale and are more readily absorbed by the blood, so that anæsthesia is induced more quickly and more quietly and can be made to reach a more profound depth in a short time. Teter[3] found that of 40 women who inhaled warm nitrous oxide (90° F.) many were unconscious after two or three breaths, whilst if cold nitrous oxide were given, the majority were conscious up to the tenth, and some up to the twentieth, breath. Ether vapour when warmed is less disagreeable to inhale and is less irritating, so that it causes less secretion of mucus and saliva. Nausea and vomiting are stated to occur not so frequently, but large numbers of cases must be compared before

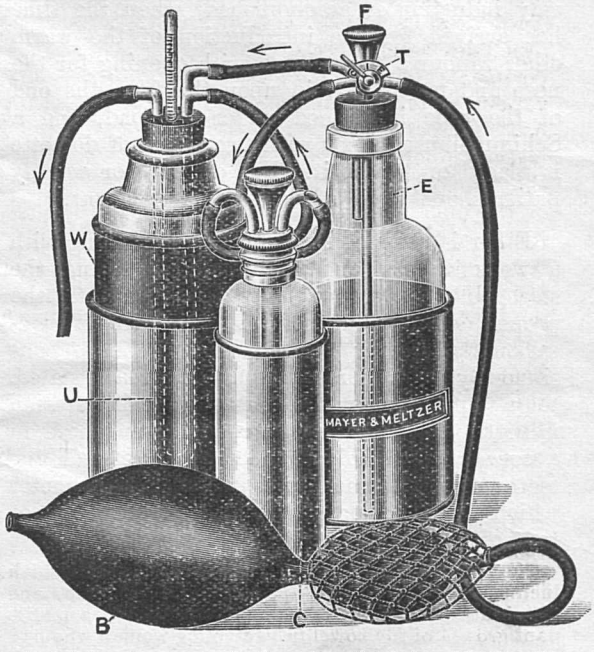
this claim can be considered to have been definitely proved. My own impression is that vomiting is slightly less, but "open ether" has given us very good results upon which it will be hard to improve. Certainly smaller doses of atropine can be used. Another advantage of the decreased irritating effect is that muscular spasm and congestion of the upper air passages are considerably diminished. Breathing is calmer and slower and very similar to the chloroform type, so that it is easier to secure quiet anæsthesia and good relaxation in difficult subjects. I find that an "airway" is seldom needed; either nasal respiration is adequate or a mouth prop, which separates the jaws to a slight extent, secures the desired type of breathing.

This ease of breathing, representing the elimination of the asphyxial factor and consequently less strain upon the cardio-vascular and respiratory systems, together with the smaller loss of body heat, helps to diminish shock. Patients leave the table in better condition than when "open ether" or other cold vapours have been used, and do not so frequently complain of feeling chilled on recovery. The diminution in the loss of body heat is a factor of immense importance in patients who are badly shocked, or ex-sanguinated, or very toxic. I hear from Captain G. Marshall, R.A.M.C., who is serving as anæsthetist in a Casualty Clearing Station, "somewhere in France," that warm vapour anæsthesia is the best method for the patients who have grave abdominal wounds and are cold and nearly pulseless, and that he has "helped to fit up two makeshift duplicates of the apparatus for other people." I think that lung complications should also be less frequent; this will be a gain considering the rather reckless way in which ether is used at present.

The apparatus which I use consists of four principal parts—viz.: B, a hand-bellows of large capacity; E, an ether bottle; C, a Junker chloroform bottle; and W, a warming chamber (vacuum flask). E, C, and W are contained in metal stands connected together, that of C being detachable, and as well as that of E being of larger diameter than their respective bottles, so that they act as water-jackets to prevent excessive cooling of the anæsthetic.

In the cork of E are: (1) an efferent tube; (2) a filling funnel (F); and (3) a regulating tap (T), the long limb of which is plunged into the ether; perforations at the end of this limb break up the air current and prevent splashing of the ether. To the proximal of the two short limbs of T is attached the hand-bellows; the distal is connected by rubber tubing with the afferent tube of C. The efferent tubes of E and of C are connected by tubing to two branches on the afferent limb of U, which is a metal U-piece immersed in the warm water of W. The delivery tube of U carries 30 inches of rubber tubing.

By regulating the lever of T air can be pumped (*a*) through E, (*b*) through C, or (*c*) in varying proportions through E and C at the same time, so that the vapour of ether, of chloroform, or of mixtures of the two can be given. The anæsthetist will find it a great convenience if he is using chloroform and the colour is pallid or the breathing weak, to be able to add ether or substitute it entirely for a time. A very strong ether vapour can be obtained and can be made still stronger by placing warm water in the jacket. The hand-bellows is of such a size that it fills the hand comfortably, and continuous pumping is not wearisome. By squeezing it regularly with inspiration the anæthetist soon acquires the habit of delivering a practically uniform dosage. He has two means of altering the strength of the vapour, one by regulation of the tap, the other by varying the vigour of his squeezing. Regularity of administration means evenness of anæsthesia, and this means an anæsthesia which can be kept lighter and yet efficient.



About 6 or 8 ounces of ether should be placed in E. If chloroform is not wanted, C and its jacket can be detached altogether if desired; the distal limb of T is then connected with the free branch of U. In this case all the air can be pumped through E, or any part of it, the rest going on to W. It has been my aim to make the apparatus as simple as possible; it is efficient and easy to use, and gives adequate anæsthesia with ether, chloroform, or mixture in any operation. The anæsthetist is independent of electric or other systems of heating, and can depend upon the temperature of the vapour remaining remarkably constant for a considerable period; it is very seldom necessary to change the water in the flask.

Anæsthesia is induced in any way thought desirable. My own plan is to give a preliminary injection of atropine, with or without morphine and scopolamine, and to induce with chloroform or a mixture, using a drop-bottle or

the apparatus; in the latter case the end of the delivery tube is placed under the mask, which holds in its place, or passed through the domette covering it. It should *not* be attached to any connection or metal tube, or much of the heat will be abstracted from the vapour; ether vapour quickly picks up and quickly loses heat. Beginning with chloroform, after a little time a mixture weak in ether can be given, then less chloroform and more ether, until finally pure ether is being administered. If induction is accompanied with struggling or with raising of the head and shoulders it is advisable to use a drop-bottle until quiet is obtained; the vapour method can then be used again. In whatever way induction is accomplished, when the time has arrived for the introduction of the warm ether vapour a flannel pad with opening for the nose and mouth is laid upon the face, the end of the tube is slipped under the pad, and a Schimmelbusch mask with two layers of domette is placed on top of it. For children or weakly patients one layer of domette is sufficient.

Ether is pumped in cautiously, beginning with a weak vapour and gradually increasing the strength as tolerance is established, until the proper degree of anæsthesia is obtained. Occasionally it may be necessary to pump continuously, for a short time, but, as already stated, regular pumping with or just before inspiration is best. For mouth cases the tube is placed in a curved metal holder which rests between the teeth, or is attached to a soft rubber catheter which is passed down the nose to the edge of the soft palate.

The longest anæsthesia in my series of cases, which includes practically every operation, lasted 3 hours and 22 minutes, the operation being for removal of a malignant growth of the bowel from a young woman who had lost 3 stones in weight, was toxic and anæmic from malnutrition; 6 ounces of ether were used, the average temperature of the vapour being 86° F. This was a smaller consumption than usual (the average being under 4 ounces), the patient being an easy subject to anæsthetise, but I feel that "open ether" could not have given me such a good result nor such a good recovery as was made, and I doubt very much whether it would have been wise to give a cold vapour, especially to this patient, for such a long abdominal operation.

At what temperature should the vapour be delivered? There is no need to warm it artificially in very hot weather above the room temperature; in cold weather 85°—90° F. will give good results, the higher level being better for patients who are feeble or shocked, or for operations which involve much exposure and loss of heat or much bleeding. Too much heat produces sweating and flushing of the face and neck, and an unusual amount of bleeding in the wound, due to dilatation of cutaneous vessels. The following observations illustrate the results that may be expected at different room temperatures, and with water at different temperatures :—

	Room temperature.	Water in flask.	Temperature of ether vapour at end of 30 in. of rubber tubing.
1	82° F.	102° F.	87° F
2	75°–76°	96°	82°
3	71°	105°	86°
4	67°	133°	90°

References.—1. Med. Record, Oct. 14, 1905, p. 609. 2. New York Med. Jour, June 1st, 1912, p. 430. 3. John Hopkins Hosp. Bulletin, April, 1909, p. 118.

Pass List.

University of Oxford.

The following degrees have been conferred :—

M.B., B.Ch.—C. Dean, A. Traill, A. G. East, D. M. P. Whitcombe.

Royal Colleges of Physicians of London and Surgeons of England.

At the Final Examination held recently, the following candidates were approved in the undermentioned subjects :—

Medicine.—P. G. MacEvedy, A. R. K. Dina.

Surgery.—J. G. Jones, E. S. Bowes, V. R. Hirsch, K. L. Bates, A. H. Taymour, E. A. Leviseur.

Midwifery.—D. H. A. Galbraith, E. C. Le M. Morgan, A. M. Ahmad, J. R. R. Brogden, E. S. Phillips, L. S. Gathergood, H. L. Bensted, R. L. Portway, J. A. Martin.

Royal College of Surgeons of England.

L.D.S. Preliminary Science Examination.

The following candidates were approved at the Examination held in January :—

E. F. Wilson, W. D. Hatton, S. V. White.

At the First Professional Examination for Licence in Dental Surgery, held January 27th and 28th, the following candidates were approved in the undermentioned subjects :—

Mechanical Dentistry & Dental Metallurgy.—H. L. Ide.

Mechanical Dentistry.—E. S. Goodwin, R. S, Roche, T. A. Wilson.

Dental Metallurgy.—L. Rabinowitz.

Society of Apothecaries of London.

Midwifery.

At the Examination held recently, H. M. Gray was approved.

Alcohol and the European in the Tropics.

At the Temperance Demonstration, which was held in the Jubilee Hall on November 26th, 1915, Dr. Pedley, who was in the chair, spoke as follows :—

The chief factor in the disability which the climate of the tropics entails upon the northern man is the difficulty which his system finds in the elimination of waste by oxidation and combustion. In a cold climate these superfluous materials and waste by-products of the work of the whole system are burnt off, but this is difficult, and is imperfectly accomplished in the surrounding high temperature of the tropics. Hence the strongest man amongst us feels enervation, drowsiness, slackness, and other sensations familiar to us all. Alcohol in the smallest quantities increases the difficulty. There is an accumulation in the blood of these waste materials which is the actual cause of sensations of lassitude and weariness. It is a common experience that these feelings are rapidly overcome when one passes into a lower temperature, as on a visit to the hills, or on the voyage Home. What really happens is that the waste is rapidly burnt off and eliminated by the change from a high to a lower temperature of the atmosphere. Exercise and abstemiousness in the consumption of heat-producing food have the same beneficial effects, a fact also familiar to most of us.

Now alcohol is a poison, for it hinders the elimination of these waste matters. It is its nature to claim a first place in getting out of the beautiful machine which its presence has defiled. It insists upon being first burnt off and eliminated, other materials must stand aside, meanwhile the ordinary fuel is incompletely consumed, and the cinders are banked back and accumulate, until the time comes when a clearance can no longer be delayed. For this purpose comes a "bilious attack," with its familiar symptoms. The doctor cuts off the alcohol, and Nature cuts down the food, starvation gives the eliminative and digestive organs a chance, and we are ready to go on again. Mind you, a teetotaller can do the same thing by overeating, but usually it is the drinker who suffers most often in this way. How often one meets men who have periodic attacks of such illness —generally ascribed to the climate, but really due to their own perversity or ignorance. Alcohol is no use as a food, and it does not give strength, nor does it aid digestion. These are incontrovertible facts, scientifically proved by the leaders of my profession. So, when a man has taken sufficient food into his system to keep him going, it is absolutely unnecessary for him to add to it a dose of alcohol. He might just as well, after finishing an ordinary meal, eat two tablespoonfuls of butter as take two tablespoonfuls of whisky.

The gradual effect during years of the most moderate use of alcohol as an article of diet is the more or less premature degeneration of the tissues of certain organs, as the liver, blood vessels, heart, kidneys. Other things being equal, these changes will take place more rapidly in the tropics than in cooler climates. For this reason, if for no other, I have no use for this drug as an article of diet. And I am confident that the man who wishes to keep fit, who wishes to live a long and healthy life and have a good time, who wishes to use his entire force on behalf of himself or his fellowmen, can do so best and longest by entirely avoiding alcohol. Why do people drink it? Because the sensations which arise from its stimulating and narcotic properties are to most men very pleasant and are regarded as harmless. For the same reasons millions use opium and Indian hemp. Chloroform, ether, cocaine, also yield the same delicious sensations and may quite as reasonably be taken in appropriate doses. Another most important reason for abstaining from the use of alcohol in the tropics is the fact that it interferes with the immunity from contagious disease. The great majority of diseases which shorten men's lives in the tropics are due to germs. There is in all of us a wonderful faculty of natural resistance to these enemies of our race. It has been proved beyond all dispute that alcohol lowers this power and renders men more liable to the attacks of tropical disease.

So after 37 years residence in this country, and in practice amongst all classes of European and Asiatics, I have no hesitation whatever in saying that watching men and women from a purely scientific standpoint I have seldom seen any one benefitted by the use of alcoholics. I have seen thousands of cases where it has done serious harm. In my mind's eye I can see a long and mournful procession of men I have known, passing to our Rangoon cemeteries twenty or thirty years before their time, directly or indirectly through alcoholism. Many of them could not be said to have taken it in excess, but what they took lowered their power of resistance to the diseases which killed them. If I am asked as to the most fatal and dangerous disease to the European in the tropics there is only one answer, alcoholism. Its victims far outnumber those of malaria, typhoid, or dysentery, and many more soldiers have died through its effects than from all the actual fighting in India. Let us thank God for the effort and example of many noble officers of our Army in India who have set their faces against this course, and who with the Army Temperance Association have done so much for the happiness and honour of the British soldiers. Sir Frederick Treves' account of the drinkers who fell out of the ranks on the March to Ladysmith is familiar to us all, but who can help feeling enthusiastic for the cause of temperance in our army when one thinks of the example and precept of the man who after 41 years as a teetotal officer in India led the other army to Pretoria?

About ten years ago I was at home and at my old medical school. It was the annual prize day and festival, an occasion on which old students came from far to

meet old friends. I was chatting with a group of a few men who were my fellow-students in the old happy days. To us came the senior consulting physician, since then President of the English College of Physicians, and now President of the Royal Society of Medicine; a prince amongst doctors, and one whose treatise on the practice of medicine is probably more widely read by English-speaking doctors than any other. He was my old teacher, and said, "Well, Pedley, how long have you lived in that awful climate?" I said, "27 years, sir." "Well," said he, "but you don't look yellow, washed out, and anæmic like so many who have lived so long in India. You must be a teetotaller or a vegetarian, is it something of that kind, what is it?" When I admitted that I was practically a teetotaller, and that I eat very little animal food, he said, "well done, that accounts for it." Those words, spoken half in jest, made a deep impression upon me. I know that there is the verdict of science and medicine worthy of the name. It is good enough for me.

I have known a few men who have in this country avoided the use of alcoholics, and I have watched with great interest their good health and success in life. I have seen them rise steadily from subordinate positions, and seen their rise accelerated by others who believed in the use of alcohol as an article of diet dropping out of the ranks. Ten years ago a man came and sat down by me on the deck of a steamer and said "You don't remember me, Dr. Pedley?" "Well," I said, "I somehow remember your face, but I have forgotten your name." "Well," he said, "I've not forgotten you and never shall. I am ——," and he mentioned a name known throughout this province especially amongst Scotchmen and engineers. "Fourteen years ago, I came to you for advice, and I asked you whether it was necessary or advisable for me to take liquor in this climate, for I had recently come out from home. You said, 'don't touch it, it is not necessary but harmful.' I took your advice and am grateful to you for what you said then." During the last ten years I saw that man continue to rise and prosper, and he lately gained his prize, has gone Home to well earned rest and comfort with an unimpaired constitution. I could give you many other examples but time forbids. I must now close. I hope that what I have said may encourage those who have decided upon total abstinence to hold on to their principles, and may help some who are inquiring or hesitating, to join our ranks forthwith.

26th Nov., 1915.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Guy's Hospital and the War.

An Extract from THE HOSPITAL, *Jan. 29th, 1916.*

One of the large London hospitals—namely, Guy's—has not adopted the general policy of accepting the War Office grant for the treatment of wounded sailors and soldiers; and in taking this exceptional course the authorities were actuated by the desire to maintain at its full capacity the accommodation for civil cases. The governors took into consideration the fact that the acceptance by the other London hospitals of the Government proposals would diminish the then existing facilities for the treatment of civilians, and in their wisdom they decided that it was their duty to place themselves in a position to accept, whenever possible, civil cases for which no room could be found in other hospitals on account of the military encroachment there. They were also influenced in their decision by the circumstance that the amount of hospital accommodation on the south side of the river is relatively small. They suggested to the War Office, however, that huts might be erected in the hospital grounds for the accommodation of about a hundred and fifty beds, and made the generous offer to regard the beds, so long as funds were available, as part of Guy's Hospital, without further expense to the War Office than that involved in the erection and furnishing of the huts. While this offer was appreciated by the military authorities it was not accepted, but an opportunity occurred for the governors to help on a smaller scale. When it became known that there was a shortage of beds for officers a large ward of forty-eight beds was set aside for this purpose, and a letter was received from the King, expressing His Majesty's pleasure on hearing of the arrangements that had been made for treating so many wounded officers without the ordinary patients suffering. It should be added that no government grant is received in respect of this accommodation. It is interesting to recall that the Stephen ward—the ward which is now in the occupation of sick and wounded officers—was thoroughly renovated eighteen months or so ago. The floor, upon a solid concrete foundation, was laid with a tile design in plantation rubber, presented by the Rubber Growers' Association. The anticipation that the demands on the hospital from the civil population would be greater than in normal times owing to the fact that a large number of beds had been allotted by other hospitals to naval and military cases has proved to be correct, and at the present time the waiting list is exceptionally heavy.

The reception of civilian patients who, in the ordinary course of events, would probably have been treated at one of the other London hospitals and the allocation of a ward to wounded officers by no means exhaust the story of the work Guy's Hospital is doing in connection with the war. A ward of twenty beds has been devoted to minor surgical ailments, and as a result of treatment received there over a thousand men have up to the

present been enabled to enlist for war service. Selected men who offer themselves as recruits for the Army but cannot be accepted there and then because of some physical defect which is amenable to treatment are sent to this ward so that their defects may be remedied, and in this way Guy's Hospital transforms the physically defective into serviceable recruits ready to be made into soldiers. For the extremely important work—work of great national importance—the hospital is doing in this connection no grant is received. In the majority of cases the defects consist of hernias and varicose veins; loose cartilages in the knee are also common. This kind of work is, of course, carried on at other hospitals; but we have not heard of any other voluntary hospital setting aside a ward for this special branch of military service, without accepting any grant in return from the Government. The hospital has also provided dental treatment for thousands of recruits in addition to treating wounded soldiers with fractured jaws.

In order to carry on this valuable work with as little interference as possible with the facilities provided for ordinary patients additions have been made to the available bed accommodation, and the number of beds is now not far short of seven hundred. Under normal conditions the hospital is dependent upon voluntary support to the extent of about £30,000 a year, and, in view of the present higher cost of maintenance, and of the increased demand upon the services of the charity, the Governors look for an even larger measure of financial support from the charitable public at this season, and during the present crisis, than has been given to them in the past.

The Puritan and Softy.

Who fed the Teuton with Free Trade?
Who laughed at what Lord Roberts said?
Whom hath the gentle German bled?
The Puritan and Softy!

Who treated all his dear recruits
To lime-juice and unnatural fruits;
And tried to make them girls, not "brutes"?
The feeble-minded Softy!

Who caused the Neutral Countries' sneers
At Parson-ridden Volunteers
Coerced by women's threats and jeers?
The half-baked silly Softy!

Who funks the R.C. Irish Mick;
And says that L.G.'s still a brick?
Who ought to get a good rump kick?
The Coalition Softy!

Who made dark, dismal old London
Less free than Berlin by the Hun,
With "purity" that takes the bun?
The Lawyer and the Softy!

Who said that war was all a myth,
With rant and cant most lofty?
Who should be kicked till he is stiff?
That perfect fool, the Softy?

ODE BY H. N. R., M.R.C.S., L.R.C.P.

The Position of Women.

II.

L'histoire c'est la statistique en mouvement, says Michelet, the French historian, *la statistique c'est l'histoire en repos.* Blue books are the only guide to social history, the one shred of fact in a world of theory and conjecture. That is to be my excuse if in the course of this paper I have to weary the reader with a reiteration of dull percentages and rates per thousand. Yet, viewed with imagination, even a census return becomes endowed with a certain humanity, the endless idiosyncracies and emotions of the man in the street, welded by a sort of magic into a coherent whole, as of a crowd moving or moved by a common impulse to an unknown goal. The grim figures for divorces granted, convictions for drunkenness or in default of fines, illegitimate births and the high death rate among these children, the high percentage of spinsters in one town, and of widowers in another, form, as it were, a human tide mark, a shifting record of the world's misery. A village preacher whom I once heard frightened his auditors by telling them that every minute sixty souls went to the judgment seat of God. Translated into terms of religious imagery, even the Registrar General's returns constitute a fearful warning to the unregenerate! We seem in some way to have realised this in the present conflict, since the talk is not of splendid charges and consummate generalship, but of Germany's dwindling army of 4,000,000; the output of the Allies in millions of shells, and the vast army (whatever the figures may be) that Russia is to have ready in the spring.

There can be no doubt that the emotional strain of the early days of hostilities saw an increase in the marriage rate both here and upon the Continent. In France owing to the special facilities accorded to men called up to arms, there were in Paris alone 30,000 marriages in the first four days of mobilisation. And though a considerable number will have to be deducted from this total to allow for the union of those who had been previously living together—since the French law takes no cognizance of the "unmarried wife"—many must inevitably have married who under other circumstances would have deferred it for months or years. In this country, too, the soberer records of the Registrar General's returns bear out the picture press as to the activity of "Cupid in wartime." The figures for the December quarter are not as yet available, but an analysis of those for the first year are sufficiently striking. The increase has been mainly in the industrial and more densely populated counties, while in some of the agricultural districts there has been actually a decline. In London the marriages in the second quarter of 1915 were 15,065 compared with 11,218 in the corresponding period of 1914. In Middlesex there was an increase from 2,322 to 3,054;

and in Essex the figures rose from 2,565 to 3,637. In Lancashire the marriages in the June quarter of 1914 were 11,451, and in 1915 they were 13,136. The figures also rose appreciably in the West Riding of Yorkshire, in Surrey, Sussex, and in Hampshire. The increase was least marked in counties like Westmoreland and Cumberland. Wales contributed very little, and in four counties—if Monmouthshire is included—there was an actual decrease. The returns, says the report bear out a general impression that the high marriage rate is attributable partly to war weddings and partly to the prosperity of the workers in areas where war work is done.

But important from the national point of view as an increase such as this is, it must be borne in mind that the conditions producing it are obviously of a transient nature, and in the event of a prolonged conflict—which seems in every way probable—our marriage rate will decline inevitably and with it the birth rate. The past year has, in point of infantile mortality, been disastrous. The unavoidable curtailing of medical services and school clinics and the whole time occupation of thousands of working-class mothers in munition factories has gone far to bring the average for the whole of the kingdom up to the level of the blackest towns of Lancashire and Stafford. The extent of our infantile mortality is a question which will claim the imperative attention of reformers in the near future. It is useless to bewail the falling birth rate, the alleged "immorality" of the working classes in their open use of contraceptual methods, when the nation at large is so profoundly regardless of the annual holocaust of babies. Surgeons regard chloroform as a dangerous anæsthetic with its mortality of one per thousand. But in England and Wales our annual sacrifice of infants under one year averaged, in 1911, 130 per thousand! In Birmingham where 80 per cent. of the mothers work in factories, it is 200 per thousand, and in the counties of Lancashire and Durham, in both of which married female labour is extensively employed, it is 154 per thousand. In the agricultural counties it is comparatively low. Hereford, the lowest, has 81, and in Ireland, a much poorer country, it is 86 (1912). In Manchester the death rate of illegitimate children is 306 per thousand; in one—the poorest—district it reaches the amazing figure of 423. At the other end of the scale we find that of the children of doctors, only 60 die before reaching their first year, and in Hampstead Garden Suburb only eleven! It it evident. therefore, that given decent conditions, no more poor children need die than, say, sixty per thousand, the figure at present only reached by the offspring of medical practitioners, a class whom one may regard as the ideal of intelligent parentage. Apart from those who actually die, there exists a vast class of permanent defectives, whose early conditions have been almost entirely responsible for their disability. Of 6,000,000 elementary school children in England and Wales, Dr. Woodhead estimates that only 1,200,000 are normal, and some one per cent. are feeble minded. Children form 25 per cent. of our paupers and 150,000 are feeble minded. In Norfolk the Medical Officer of Health says that only 25 per cent of school children are in perfect health. In 124 schools in London over 16,000 children were verminous. Half the girls in urban and a quarter in rural schools have dirty heads; 20 to 40 per cent. have four or more decayed teeth; 10 per cent. suffer from eye defects. The average standard is in no case very high. In the L.C.C. schools three decayed teeth are charted as normal; many slight eye defects, many slight degrees of feeble nutrition, and many slight deformities are "normal." In industrial areas 13 per cent. show malnutrition, 30·5 per cent. defective vision, 18 per cent. diseases of the nose and throat, 21 per cent. uncleanliness of the body, and 80 per cent. dental caries. In rural areas the percentages are considerably lower (1914). There are in England 400,000 crippled and deformed. Sir John Byers, M.D., stated recently that 85 per cent. of the cases of deformity are due, not to malformation at birth, but that they arise subsequently. The same is, of course, true of mental defectives, consumptives, and other defectives, where a natural delicacy has been driven over the border line by neglect and lack of nourishment. These few figures, dull as they are, do give us a slight picture of the morass in which our children are born, reared, and beget their like. What, one may ask, do they know of Mile End who only Mayfair know? And what is more, what do they care? If we were really a practical nation instead of an obscurantist nation. we should do some very simple things to remedy this. As things stand at present, every humane man regards the falling birth rate with unqualified relief. Of what use is a rising generation if the conditions of its birth and rearing are such as to leave it bearing the scars throughout its life? Conscious of this there is a tendency among the more enlightened working classes for a voluntary curtailment of their families. Sidney Webb, in an interesting pamphlet on the subject, the result of an inquiry among members of the Fabian Society, including all grades of society from the skilled artizan to the professional man, though presumably all of them persons exercising foresight and thrift, has shown that when all necessary deductions have been made, the number of fertile and unlimited marriages for the period 1875—1902 out of a total of 252 cases was only 28, the remaining 224 families having voluntarily restricted their offspring, generally to two or three. Moreover. in the decade 1890—1899, which may be regarded in many respects as typical, we find that out of 120 marriages, 107 are limited and 13 unlimited, whilst of these 13, five or six were childless at the date of the return. In this decade, therefore, only seven

or possibly eight unlimited fertile marriages were reported out of 120. It may be argued that the classes from which these figures were obtained were hardly typical of the bulk of the community, and one must admit that this is undoubtedly true. The point is rather that with the increasing standards of personal comfort the artizan and labouring classes will come to a realisation that from their own point of view such a limitation is highly desirable. The more far-sighted and provident the parents, the more likely will such a limitation be. Moreover, the active propaganda of such societies as the Neo-Malthusians, place the necessary knowledge and appliances within the reach of all who care to apply for them. In the hands of capable agitators a strike in the birth rate could be made the most powerful of socialist weapons. In many places a strike of this kind is being actively advocated. What, then, is the position with which we are now faced? The birth rate is falling, it is falling, too, in the very classes whose qualities as citizens make their propagation highly desirable. It is maintained almost entirely by the reckless breeding of the classes immediately above and below the destitution level. The bulk of the nation's children never. as we have seen, attain their full level of effectiveness owing to the poverty, neglect, and poor housing of their parents. A shamefully large percentage never reach the first year of life. Further, the growing intelligence of the labouring classes makes it probable that the birth rate will shortly fall even lower. In addition, the economic conditions of the war have sent a large number of young mothers back to the factories, a state of affairs which, as in Birmingham, leads to a large increase in infantile mortality. Many young men will succumb before reaching the age for marriage, others, though already parents, will be cut off in the midst of their procreative period. To those who believe that a rising birth rate is the only test of a nation's virility, the outlook is not a rosy one.

Yet what is to be done? One thing at least is certain. The Community must step in. But granting the need for State intervention what form is it to take? Are we to replace the home by State Institutions, or shall we set ourselves to build the home anew? Let us consider the former alternative. We have so long prated of the sacredness of motherhood, and so long watched unappalled the ghastly sacrifice of both mother and child, that it is high time the business was taken out of the realms of sentimental incompetence and the welfare of the coming race efficiently safeguarded. Plato advocated State nurseries more than two thousand years ago, and various modifications of his plan have attracted advanced thinkers of all ages since his time. In some respects modern practice in England is already tending in that direction. We have no fewer than 350 school clinics, where the health of school children is periodically examined. The establishment of numerous Baby Clinics and Schools for Mothers are all signs of the gradual realization of the importance of young life. But little as yet is done to care for the mother in the ante-natal period, and in London only about 10 per cent. of the cases of childbirth are treated in lying-in hospitals. But the tendency is nevertheless growing to divest parents of their responsibilities and force the community to take them up. It is only a few steps in one direction from the present state of things to the complete State maintenance of children, and the practical abolition of the family as a social unit. We might have State or Municipal hospitals with maternity wards, to which every woman could have access, where babies could be launched into life under ideal sanitary conditions, be well fed, nursed properly, given the best possible start. Then we might have public endowment for the encouragement of nursing mothers, side by side with public crèches into which the children would be drafted and remain under perfect conditions of food, air, and nursing, until old enough to go into the public nurseries or kindergartens which would replace our present infant schools, and where physical and mental development would be carried out on a progressive system until the children were of age to enter the public elementary schools. In the schools, too, meals would be arranged for as at present in the upper and middle class schools. By some such means as these, the budding citizens could be rescued from the evils that beset them now, and home life already more than half destroyed by modern industry, should be supplemented out of the wealth that industry produces. But there is no doubt that an ideal such as this would meet with the bitter opposition of that powerful class of opinion which wages perpetual warfare against any interferance with home life. The ignorance of facts, terrible every day twentieth century facts, is pitiful, the talk of the sanctity of home life in the main, the idle chatter of the upper class sentimentalists who imagine the life of the poor man is a romantic struggle to keep the wolf from the door. Their views would be unworthy of mention, save that they are in a position to express their opinions in the press, whilst the poor man who has views of his own on "home life" on a pound a week or thereabouts generally has no time for writing letters to the papers.

The fact of the matter is that the war will only accelerate a change which has for long been inevitable. Exhausted by the double burden of factory work and maternity the working woman will either renounce her right to bear children or do so upon her own terms. Whether we (by "we" I mean the governing classes) are to wait until the need for children becomes as pressing as in France, where all manner of fantastic schemes were proposed to induce poor people to have children they did not want, or step forward frankly and openly and take from the working mother the responsibility for children which she cannot rear, remains to be seen. But undoubtedly the time will come when a great division will appear in the work of women, and the cry of "maternity for all" be changed to one of "maternity

for the elect." One supposes that the increasing and almost universal employ of women in all industrial processes, will in time develope a worker type, similar in function to the worker bee, whose female sexual apparatus atrophies shortly after birth, whose chances of maternity will be comparatively small. This type will, one imagines, be trained in the same way as her brothers, be employed on equal terms, and any defection from the ranks by reason of maternity regarded with disapproval. And there would be the other class, the mothers, whose function would be motherhood, and by motherhood is meant not the casual affair of to-day, ill-regulated, unexpected, unsought; but the systematic rearing of healthy, beautiful children. And for this would be necessary careful selection, as much on grounds of physical fitness as natural inclination, a period of careful training and preparation, so that in the earlier years the mother should have the joy of educating her infant. Moreover, during the actual period of gestation she would be compelled to pay the strictest attention to regularity of life and diet, that the life in her charge should not be imperilled thereby. And for this work the State would afford her adequate recompense, so that she would not he dependent upon her mate, nor looked down on by her working sisters who were playing their part in the economic duties of citizenship. If it were decided to leave the infant entirely to the care of its mother, then she would be required to bring it up for inspection at frequent intervals, and her remuneration would be dependent on the care bestowed upon the child. If there were evidence of neglect, she would be warned, and if it persisted the child would be taken from her, and she punished. Thus the mother would be made to understand that maternity had its responsibilities, and that the parent is only the guardian appointed by nature to care for a life that belongs to the State. At no time would the mother be exposed to the fear of pecuniary embarrassment, and when her time for motherhood was finished a pension and a home provided for her. In some such way, I take it, will the State of the future impress upon its citizens that motherhood and all that appertains to it is the highest of all human functions, and the life of every infant worthy of the maximum care that science and humanity can bestow upon it.

Students of comparative religion tell us that in many notable instances they find a common trait which may be called "mother and child" worship. The colour of the creed may be ethical or dogmatic, or—as in our case—both. But the idea persists that the mother—guardian of mankind—who is born the most helpless and remains the longest helpless of any being—is deserving of special reverence. To-day, when young lives are sacrificed in the hundred thousand in what we believe is the cause of liberty, is surely the time for a revival of the cult of motherhood—in Walt Whitman's brave words, "The mechanic's wife, with her babe at her nipple, interceding for every person born." For in that alone lies the hope of the future.

G. H. F. G.

To a "Guy's" Nurse.

(C. L. P.)

To you, my nurse,
I humbly bring,
A grateful verse
As offering.

A song of praise—
Of memory,
For all the days
You tended me;

For kindly hand
And kinder face
That nature planned
With healing grace;

For thoughtful deed
And watchful eyes,
Far-seeing need
That might arise,

Until I lay
Content—and smiled
To go your way—
Your trusting child! . . .

. , . To your kind hand
I'd bravely cling
Across the land
Of suffering,

So sure that you—
With God's goodwill—
Would lead me through
And hold me still!" . . .

We part, dear nurse—
The end must be!
This idle verse
A treasury
Wherein I guard your care of me!

M. R. H.

Birth.

ZORAB.—On December 18th last, to Mr. and Mrs. Arthur Zorab, at 21, Carlton Crescent, Southampton—a son.

Marriages.

JUPP—PASCOE.—On January 12th, at All Saints, Frindsbury, Edgar Norman Jupp, M.R.C.S., L.R.C.P. London, of Chard, to Elizabeth Maud, second daughter of the Rev. S. and Mrs. Pascoe, of Newquay, Cornwall.

HAWARD—TYERS.—On December 2nd, 1915, at Holy Trinity Church, Karachi, Edwin Haward, of the *Civil and Military Gazette*, Lahore, to Gwendoline Maud Tyers (late of Guy's Hospital).

Death.

MACILWAINE.—On January 19th, at Clevedon, Somerset, Sidney Wilson MacIlwaine, M.R.C.S., L.R.C.P. London, aged 61 years.

F. A. K.

GUY'S HOSPITAL GAZETTE.

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Passim.

IN our last issue of the GAZETTE we suggested to those Guy's men—still left in that unenviable condition of mind, namely, of not knowing whether to attest or not—that they should betake themselves to the local authorities at the Southwark Town Hall. Since that time we have almost daily heard this one and only topic discussed. Nevertheless, much satisfaction apparently has been obtained by those gentlemen who have managed to rush down and sign on for "active service!" Whether one has signified his willingness to serve, by filling up a form for "general service as a combatant," or for "absolute" or "temporary" exemption therefrom, it does not seem to matter very much—we *have* attested; and for the rest! well, we trust that ere long we shall have some final pronouncement on whether we have a chance of finishing, at least, those appointments which we have undertaken.

WE have heard it argued that a medical man cannot attest by law, there being some hidden-and-forgotten army act against such a procedure. Whether this be so we know not. Certainly when one considers this question, it does seem a little strange that a medical man has to go to a recruiting office, occupy the time of the recruiting officials, not to mention his own valuable time, is given two shillings and ninepence, and the result of all this is—that in a brief space of time that same man is at the War Office, this time, presenting himself for a "commission." Surely common sense dictates that it is unreasonable for a medical man to have to attest; yet we must continue to wonder what those in authority on these matters will eventually advise.

WE have just been informed on good authority that all fourth and fifth year students must now attest, and that when doing so they should have with them their "letter of exemption." In addition to this it will be required of them that they join an O.T.C. This, we venture to think, will be a wise thing to do in the interests of the student himself, still more in the interests of the State. For Guy's men this will not be a great burden, as we have an O.T.C. excellently managed by one of our own staff, with parades held in the hospital itself.

ONCE again we hear that a change will shortly take place in the arrangements of the College catering. We sincerely trust that the approaching alteration will meet with general approval, and we feel sure that the few men, under the present state of affairs, who frequent the Dining Hall will be well satisfied with but a very plain menu, tastefully and skilfully served. We earnestly hope that all will support and help the Catering Committee in their difficult task.

WE were sorry to hear of the illness of Sister Dorcas, but it is good news to hear that after a short holiday she will be able to resume her duties again.

Home Service.

SEVERAL times during the last nine months, whilst trying to get my share of the excitement which is costing us five millions a day, I have wondered whether any men of my year are similarly occupied, and it is quite as much in the hope of getting into touch with friends long lost to sight as in the expectation of interesting your readers that I send you some of my experiences as a regimental M.O.

It certainly is a great change from private practice with its lady who doesn't know what she wants and won't be happy till she gets it, and who above all things cannot bear the truth. I miss her, but am consolable.

When I started, being of a friendly disposition, I received a lot of advice which crystalized into the need for lightning diagnosis and the necessity of discountenancing absence from duty on account of sickness. As I never fell a victim to the allurements of the panel, and in the belief that men in khaki closely resemble those in serge, I paid no attention to my advisers, but examined each fresh case carefully and entered the diagnosis in the hospital book. The lengthy nature of the proceedings evidently does not meet with the approval of my orderlies when I first take over a battalion, but when they see the sick parade shrinking day by day they tumble to the idea, which is to learn to know your man.

Unfortunately, owing to the metriculous care with which the date of birth of unimportant people like myself was noted even more than fifty years ago, I find that by the time all the spade work has been done, my unit passes into younger hands on its journey to the front, and I am left to begin again with a new lot. But that my method is successful is, I think, shown by the parting promise of my last lot of boys, that if I did get over the age difficulty, and they expressed great confidence in my ability to get round people, the whole battalion headed by the band would come to the station to meet their old M.O.

Soldiers, and under this term I include officers, who come under the M.O.'s diagnostic eye, may be divided into two broad classes: First, those who are weak in body (these are also often weak in spirit). These will remain an outstanding feature of the sick parade as long as civilian doctors are paid to pass men in, not to reject them. I have come across within a few days of enlistment such cases as—withered right shoulder, useful for demonstrating ligaments of joint, but unable to lift his arm; extreme talipes calcaneus, he could waggle his foot till he made my orderly feel sick, but couldn't march; contracted fingers of right hand, preventing handling of a rifle; large inguinal hernia and shortening of leg by two inches due to old fracture of femur in a man apparently over sixty; a man with a broken down scar on edge of sole and three outer toes missing; a man with excision of the right elbow, a very excellent result, no doubt, but not much use when something heavier than a pen has to be wielded. The second class comprises those who are strong in body, but weak in spirit, who may be subdivided into those who fancy they have something beginning to go wrong, but, their fears being dispelled, willingly go back to duty. The remaining subdivision calls for quite 50 per cent. of the M.O.'s work at the beginning, but as it yields 100 per cent. of the sport, the gradual elimination of the malingerer ends by causing him a subconscious feeling of regret. Some of these have found out that they are happiest when idle, the rest are adventurous spirits who occasionally when things are dull try the sport of pitting their wits against those of the M.O. Some of my best friends are among them, they often form the black gang whose leaders have to be drafted into another company and given the responsibility of a stripe before their best points as fighting men develop. Even if this fails to steady them, their officers are inclined to be patient for, after all, you might easily have worse men by your side some day when you are in a tight corner. One youth, who had signally failed to get my sympathy and felt nettled at his want of success, turned as he was leaving the room and said. "And is this all you can do for me?" "No," I said, "if you like I'll wire to your mother to come and kiss the spot and make it well." As he was playing football next day, his lumbago was probably not as severe as he professed, and his friends' chaffing probably accounted for his not coming to see me again. Another lad, I suppose, thought he had not done sufficiently well when, after a bruised back due to a fall from his horse, a short interview with me resulted in a verdict of light duty and massage to-morrow if not better, for a few minutes later the corporal in charge of the men from his battery put his head into my tent and said the man would like to see me again. The additional information he wished to convey was that he was spitting blood, but couldn't explain why he had forgotten the fact, but he was spitting a lot. He was given a quart enamelled basin, sent to the detention room and told to spit blood until I saw him again, and not to have any dinner. Three hours later he was glad to get off with a warning and full duty.

One or more tents reserved for detained cases not bad enough for hospital are useful in camp, as you then have them under your eye. Another useful arrangement when men are in billets is to go round billets after retreat has sounded and have the roll of light duty and detained men called; any who are caught absent being reported for orderly room next day. In both situations men who have been down for light duty or detention during the week not being

given week-end passes without the M.O.'s sanction also tends to improve the health of the troops.

As soon as it got about that I was making a list out of men for discharge, I had visitors who wanted to work their ticket. One man, fortunately for me, happened to be the ugliest man in the whole brigade, so when he was leaving my presence in a very dissatisfied frame of mind, I called him back and said, "I expect the truth is that the ladies of the town can't bear the idea of losing a handsome chap like you and they have persuaded you to this silly trick. Turn them away from you and make up your mind to do your duty." Another man who volunteered for sacrifice said a specialist had told him he was ruptured. A brief examination negativing this claim, he said I had mistaken him, what the specialist had said was that he was going to be ruptured. As I said I didn't agree with the specialist, he said, "You must know, sir, that I came into the world with a 'break.'" "A brake?" said I, "Good Lord, what more do you want? Do you expect to come into the world with a motor car?" I only had trouble about inoculation in one unit and there only because a misguided M.O. lower down the hill was giving his men three days' leave if they consented. My men, being trades unionists to a man, went on strike for the same terms. I explained that I didn't believe it, and in the second place that it was against the regulations, and in the third place it was against their own interests, so that I could not consent even had the regulations allowed it, but that instead I promised them a course of lectures on the subject which I felt sure would convince them. The lectures were a great success. The first was fixed for half an hour before dinner. I prefaced my remarks by saying that I was convinced that inoculation was a good thing, that I had been done myself, and that the lectures would continue until I had driven conviction home to every man. But I had no intention to try and convert the converted, and as I did not suppose that any of them cared for a lecture which would probably last an hour any more than I should at their age, the roll would now be called, and all those willing to be inoculated that afternoon would be excused the course. When the list came to 40 and seemed likely to be no larger, I said if it got to 80 I would instead tell them funny stories until dinner time. I did in the end give a lecture, but that was to the ammunition column, and I think it was more with the idea of scoring off the batteries that they insisted on their right.

A subaltern came in one day and asked as a favour for some means of procuring him a week off. I told him it was an extraordinary request, but gave him a bottle to sniff at. It was the formalin bottle, and after he had finished coughing I told him it wasn't good form for one star to chase two stars round the table, and he ought to take lessons from the curate in enunciation, as I might have given him something to procure a strong cough instead of a weak cough if his mumbling had been any worse. Some R.A.M.C. men are inclined to be offensively patronising to their seniors in junior positions. A good tip in such cases is to give a pressing invitation to lend him things that might be useful, and if he says he doesn't think there is anything you can lend him, say, "What about brains?"

FRANCIS HEATHERLEY,
Barnard Castle. Lt. R.A.M.C.

Honours for Miss Swift.

At a General Court of Governors of Guy's Hospital, held on February 4th, 1916, the President informed the Court that the Royal Red Cross Decoration, 1st Class, had been awarded to Miss S. A. Swift, in recognition of her work in connection with the War. Whereupon the following resolution was unanimously passed:—

> "That this Court hears with much satisfaction of the distinction conferred upon Miss Swift, and desires to offer her the hearty congratulations of the Governors upon her receiving the above award."

All readers of the Gazette will be delighted and interested to read the foregoing paragraph. Miss S. A. Swift, who held the post of Matron of Guy's Hospital from January, 1901, to September, 1909, was invited, during 1914, to become Matron-in-Chief of the Trained Nurses Department of the Joint Committee of the British Red Cross Society of the Order of St. John. She has rendered most valuable services in organising and staffing Red Cross Hospitals at Home and abroad, receiving and distributing medical stores of all kinds.

The Joint Committee have also been instrumental in attaching to military and other hospitals over four thousand women workers, including voluntary aid nursing members, and general service members, dispensers, clerks, cooks, storekeepers, etc. Another distinction bestowed upon Miss Swift earlier in the year was the title of Lady of Grace of the Order of St. John of Jerusalem.

Chapel Notes.

The Missionary Society has issued its report for 1915. Copies may be had by anyone who is interested. The last meeting before the Autumn will be held on Thursday, March 2nd, at 8.15 p.m., when Captain Sinker of the Melanesian Mission will speak.

Lent.

On Ash Wednesday, March 8th, the Bishop of Southwark, Chaplain of the Hospital, will preach in the Chapel at 8.15 p.m., and at the same time on Thursdays, March 16th, 23rd & 30th, Bishop Hook will give an address.

The Puritan and Softy.

A Comment on the "Ode" by H. N. R., M.R.C.S., L.R.C.P., in the G.H.G. of February 12th, 1916.

Dear H. N. R., of Conjoint fame,
'Tis clear that you regard the name
Of "Puritan" as something tame
And fit to join with "Softy."

Yet I suppose, in bygone years,
You learnt, although perchance with tears,
That England owed some glorious years
To Cromwell and to Milton.

To you of course the public weal
Is best secured by beer and steel,
To your brave ears the King's appeal
Seemed "Puritan and Softy."

The deeds of Ireland in the field
To you no pride or glory yield,
Your party mind is still congealed
With ante-bellum passion.

Your only argument's a kick;
Your motto: "mud is sure to stick,"
And so of course you throw it thick
At "Puritan and Softy."

Still, though t'was hardly what you meant,
I take it as a compliment,
By you to be reviled and rent
As Puritan and Softy.

A. S.

Change of Address.

Lieut. V. Drew, 2nd Royal Serbian Army, to 9th Reserve Bat., Duke of Cornwall's Light Infantry School of Instruction, Bank Chambers, Chelmsford, till March 7th.

Graham Poock, B.A. Cantab., L.D.S., R.C.S. Eng., from 33, High East Street, to 3, Trinity Street, Dorchester.

H. B. Carlill, M.A., M.D., M.R.C.P. Lond., Temporary Surgeon, R.N., from H.M.S. *New Zealand*, to Royal Naval Hospital, Haslar.

Capt. D. C. Scott, R.A.M.C., S.R., McGrigor Barracks, Aldershot.

Lieut. Guy Neely, R.A.M.C., A Section, 143rd Field Ambulance, British Adriatic Mission.

Capt. J. L. Percival, R.A.M.C., from 59th Field Ambulance, to No. 7 General Hospital, B.E.F., France.

Albert H. B. Kirkman, F.R.C.S. Ed., R.A.M.C., from Staplehurst, Kent, to Tower Barracks, Chatham.

Staff-Surgeon H. R. H. Denny, H.M.S. *Collingwood*, c/o G.P.O.

The Editor will be very glad to receive a post card with notes of any change of address.)

Appointments.

Royal Navy Medical Service.

L. B. Stringer has been appointed Temporary Surgeon to the *Victory*.

A. B. G. Underwood to the *Pembroke*, additional for Chatham Hospital.

Military.

W. H. Ogilvie, M.B., B.Ch., has been appointed Surgeon to the "Urgency Cases Hospital" attached to the 3rd French Army in the Argonne.

Royal Army Medical Corps.

The following Temporary Lieutenants to be Temporary Captains:—H. W. Doll, F. Barnes.

To be Temporary Lieutenants:—R. Montgomery, P. G. Temple, H. W. Barber, A. G. H. Burton.

The following have relinquished their Commissions:—Temporary Captain H. Munro, and Temporary Lieutenants S. Reader and W. M. Thomas.

Territorial Force, R.A.M.C.

London (City of London) Sanitary Company:—F. E. W. Rogers to be Lieutenant.

Attached to units other than medical units:—Lieut. S. Hughes to be Captain.

H. B. Carlill, M.A., M.D. Cantab., M.R.C.P. Lond., Temporary Surgeon, R.N., has been appointed to the Staff of the Royal Naval Hospital, Haslar, in charge of the Neurological Department.

Indian Medical Service.

The King has approved the retirement of Lieut.-Col. W. R. Clark.

Honours.

We regret that the name of Capt. C. Gordon Douglas, R.A.M.C., was not previously reported as having been mentioned in Despatches by Sir John French, and awarded the Military Cross for Services rendered in connexion with military operations in the Field.

Captain C. W. Greene, M.C., F.R.C.S., R.A.M.C., who is now in Salonika, was mentioned in the Despatches of January 1st, 1916.

Pass List.

Royal Colleges of Physicians of London and Surgeons of England.

At a Meeting of the Comitia of the Royal College of Physicians of London on January 27th. and of the Council of the Royal College of Surgeons on February 10th, the Diplomas of L.R.C.P. and M.R.C.S. were respectively conferred on the following:—K. L. Bates, E. S. Bowes, H. H Elliott, V. R. Hirsch, J. G. Jones, A. H. Taymour.

Cases of Deafness as a result of the War.

CLINICAL LECTURE BY W. M. MOLLISON.

Gentlemen,—Apart from damage to the ear due to direct injury from shell fragments or bullets, the cases of deafness caused through the war fall into two groups. In both groups the deafness is due to the concussion of sudden loud explosions.

The first group is the smaller, and consists of cases of rupture of the tympanic membrane. The tear in the membrane is very large, usually oval in shape, and in the lower part of the membrane; there may be some discharge from the ear or the perforation may be dry: in some cases there is pain. The prognosis is good as regards healing of the membrane and the return of hearing.

The second group contains all the cases in which the tympanic membrane is uninjured and the shock has passed to the internal ear or perhaps to the auditory nerve or its centres: the result is deafness affecting one or both ears, usually one much more than the other; the ear on the side most exposed to the explosion is the more affected, as, indeed, might be expected. Tinnitus invariably occurs, and may be referred to the ear or be appreciated in the head; it is peculiarly persistent. In a small proportion of the cases vertigo is complained of, but passes off soon.

The prognosis varies greatly, and it is very difficult to give the patient definite information as to the final result. Some cases in which the deafness is apparently absolute in one ear recover a large amount of hearing after some months; others that responded similarly to the various tests show no improvement at all. Perhaps the explanation is to be found in the position of the lesion. Some cases may have sustained physical damage to the organ of Corti, others damage to the central organ rather in the nature of a shock such as produces functional loss of other special senses. These cases may and do recover, the recovery being greatly accelerated or, indeed, initiated by suggestion.

In cases of physical damage to the organ of Corti by hæmorrhage into the cochlea or concussion alone, recovery is probably impossible. The difficulty in prognosis lies in the failure of tests applied to the ear to locate the site of the lesion.

The following cases of ruptured tympanic membrane are characteristic:—

1. Lieut. M. was in May, 1915, knocked down by the explosion of a shell in a trench. Some mud was splashed into the ear; this was syringed out, and he was sent home. When seen a few days later there was a large perforation in the right membrane in its lower posterior part; the perforation was moist. He could hear a whisper only two feet from the ear. Treatment consisted in keeping the ear clean by syringing. When seen two months later the membrane was completely healed, and he could hear a whisper eight to ten feet away from the ear. To illustrate the fact that the shock had been severe, it may be added that about six weeks after the injury the patient developed attacks of loss of memory and became somewhat neurasthenic.

2. Lieut. W., 22. This unfortunate officer was practising bomb-throwing, when the bomb exploded in his hand; his hand was at the moment at the level of his head and ear. His hand was much damaged, and the force of the explosion was such that a man next him was killed and another wounded; he was deaf in the right ear. On examination the right membrane was extensively lacerated; there was a very large inferior perforation divided into an anterior and posterior part by a fine strand. The perforation was dry. He heard a whisper only six inches away from this ear. The further history of this case is not obtainable.

3. Lieut. W., 20. Seen 13th August, 1915. On 9th August, 1915, a shell burst close to him; he was buried in sand, some of which went into his ear. Since this he had had a blood-stained discharge. He had no pain, nor vertigo, but the ear was tender inside and he was deaf. The left meatus was very tender and there was a granulation deeply on the floor; there was a large perforation inferiorly and the rest of the membrane was red. He was very deaf, hearing conversational speech only four inches away from the ear. The ear was syringed with antiseptic lotion and the perforation gradually healed, and the hearing improved. Two months after the rupture the membrane was completely restored and he could hear a whisper eight feet away from the ear.

The following cases illustrate some of the features of the second group—those in which no damage to the membrane takes place, but in which deafness and tinnitus occur, and occasionally vertigo:—

1. Captain O., aged 29, was seen in November, 1914. During the battle of the Marne he was in a few minutes twice concussed by explosions of large shells; the first burst six yards from his left side and threw him several feet. On recovering from the concussion he was trying to recover an identification disc of one of his men, when the second explosion occurred, also to his left side. For five days he lost his memory and was completely deaf, and the right leg was paretic. There was some gradual recovery of hearing in the right ear. The results of testing showed that the patient was completely deaf in the left ear, and only heard a whisper two to three feet distance from the right ear. With Weber's test the sound was referred to the right ear. Rinné's test gave a normal (positive) result on the right side and a negative on the left. High tones were heard normally on the right side. Seen two months later he complained of tinnitus and some vertigo, and finds he loses his memory. The hearing of the right ear is only six inches for whisper, but the left ear now hears a whisper at two inches. The patient was again seen in August, 1915, ten months after the injury, and then heard quite well with both ears—a whisper eight feet away from either ear. The obvious lesson from this case is the possibility of recovery of hearing even when it seems to have been completely lost.

The next case to compare with the first is one in which the "shock" was physical, and not purely noise.

2. Captain M. was seen in October, 1915. He was almost entirely blind and practically completely deaf; shouting in the right ear was just appreciated. A few days before he was shot, the bullet entering just behind the right external angular process above the zygoma and passing through the head and out over the left malar bone; the wounds of entry and exit were very small, and healed. When hit the patient thought that a high explosive shell had burst near the right ear, but he felt no pain from the passage of the bullet. The ears were normal, and, indeed, the bullet had passed some distance in front of the temporal bones. Gradually the hearing returned, until at the end of a fortnight ordinary speech could be heard. Doubtless in a month or so further improvement occurred, but definite information is not available, as the patient left for the country.

Recovery of hearing does not always take place, and there follow cases that show this:—

3. Lieut. D., aged 24, was seen in October, 1915. Six weeks previously he was knocked down by some sandbags, displaced by the explosion of a shell; he felt no ill-effects except a noise in the right ear. A few weeks later he was sent home on account of "influenza" (?) When seen this officer was complaining of severe headaches and a constant tinnitus in the right ear, as of a loud whistle. He heard a whisper only one foot from the right ear, while the left heard normally (twelve feet or more). High notes were not heard quite so well in the right as the left ear. Dr. Hertz saw the patient, and tried the effect of hypnotism twice, but unfortunately with but little success. Perhaps the headaches were less severe afterwards. The patient was sent to the country for a two months' holiday; he was then seen again. The tinnitus was still present, and loud noises hurt the right ear. The hearing was as before; the only improvement lay in the diminution of the headaches.

4. Lieut. M., 26. Seen on November 24th, 1915. Ten days before he was exposed to a shell explosion at close quarters; the explosion killed two men who were near him. His right ear felt painful, but this was improving. The tympanic membranes were normal, but the right meatus was tender. The hearing of both ears was much affected; the left ear heard whisper at four feet, the right at one inch; in both ears the appreciation of high tones was very much impaired. Seen later, the left ear had recovered considerably, and now heard a whisper at ten feet, but the right heard only two feet, and the appreciation for high tones remained unchanged. Seen again two months after the shock, the hearing of the left ear for whisper was only four feet and for the right two feet It is improbable that in this case further improvement will occur on account of the great diminution in the appreciation of high tones.

5. Captain H., 27, was seen in June, 1915. He then complained of tinnitus in the left ear and some deafness. Four months before a shell burst near him on the left side; this made the left ear feel as if there was a bubble in it, and the tinnitus started. This resembled a crashing at intervals, and would wake him. The Eustachian tube was clear. He heard a whisper seven feet from the left ear, normally in the right; there was some loss of low tone perception in the left ear and of high tone perception on both sides. This case must doubtless be considered one of nerve exhaustion combined with the local effect on the ear.

These cases are typical, and indeed many more might be quoted to illustrate the results of shell shock. As a rule treatment consists in sending the patient to the country where he will be rested and will encounter no loud noises; one of the cases noticed that he was always worse when he came to London for examination. The following case is quoted to show that one must not conclude that the patient is deaf from shell shock merely because the ear was exposed to the explosion.

6. Lieut. C., 27. Seen in November, 1915, complained of deafness in the right ear. Five months previously a shell burst near him and he became deaf in the right ear; three months later he had bronchitis and pain in the right ear, and after fomentations right otorrhœa began. The right membrane was a little dull, the left normal. He heard a whisper twelve feet from the left, four feet from the right ear; perception to high tones was normal. Inflation of the right Eustachian tube, once or twice, restored the hearing of the right ear to normal. This patient had previously been told by an aurist that the right ear would always be deaf on account of the shell shock, an unfortunate mistake which emphasises the importance of complete examination in all cases.

Lastly, there are cases of functional deafness following shell shock or bullet wounds; these cases are extremely difficult to differentiate from cases of deafness like those quoted above. Diagnosis will rest upon the history, the presence of other symptoms, suggestive of functional loss, and the result of treatment by suggestion. Two cases may be quoted:—

(*a*) A trooper in the 6th Dragoon Guards was shot through the left side of the neck; the bullet entered below the tip of the left mastoid process, travelled forward and inward, and passed out through the left cheek; the wound healed well. The patient was quite deaf in the left ear, though there was no local lesion at all. He was seen again two months later: now he was found to have some loss of vision in the left eye as well as the deafness. The condition of the eye was found to be functional, and there is little doubt the deafness was also. An additional reason for thinking so is the fact that there had been no recovery at all in the ear, whereas in other cases of deafness from shock recovery to some extent always occurred in two months.

(*b*) A case under Mr. Ormond's care, which he kindly let me examine. A corporal was subjected to shell shock in April, 1915. He became blind, dumb and deaf. Under suggestion he was enabled once more to see and speak, but the deafness remained. Examined eight months after the shock he heard nothing with the right ear, and the voice at two inches distance from the left ear. He heard low tones in the left ear to some extent, but there was great diminution in his perception of high tones. He had purchased for himself an expensive electrical aid, which enabled him to hear quiet conversation in the left ear; it did not help with the right.

The fact that the sight and speech had been restored by suggestion made it very probable that the deafness was functional; also the man played a musical instrument with great success in the hospital orchestra at the Christmas festivities.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Dear Sir,—Having read with interest the papers on "The Position of Women," which have recently appeared in the Gazette, I hope that some of your subscribers may be stimulated to contribute their sentiments and experiences upon this question.

It is convenient to divide women into the groups aristocratic, middle class, and working women. For the comparatively few in the first group, their education and development from childhood to adolescence is frankly devoted to an object generally achieved—"a marriage has been arranged." Equality of position, money forthcoming from one side or the other, and Society arranging social opportunities (which are often sadly lacking for the man and maid of the middle class), had, at least in pre-war times, given the "daughters of a thousand earls" a sphere. That many found this a life of artificiality and restraint there is abundant evidence, and there is little doubt that with the terrible war, loss of potential husbands, and general impoverishment, many girls of aristocratic birth will ask what is now to be their position, and how best to be attained?

The working woman, that is, the woman who on leaving school at fourteen enters factory, workshop, or warehouse, has a position which her middle class sister cannot claim. She is instructed in a definite means of livelihood; as a wage earner she becomes of importance in the parental home; marriage and motherhood naturally follow, and her work is continued.

Here, on paper, is all that the friends of the educated girl are asking. How far the reality is from the ideal it is the duty of all to know. As pointed out by G. H. F. G., women's labour is exploited, and in-

dustrially she is unorganised. She is without political power and the advantage of union. Owing to the low economic standard of living, marriage is undertaken upon inadequate means, and there is yet that long account to settle—as to the effect upon the babe unborn and in infancy whose mother was engaged in arduous toil. All these things must be remedied, and may future generations profit from lessons taught by these failures.

We shall, I suppose, all agree that the question of position regarding the women of our own class is of most urgency and interest. Not to recognise the fact that we must adapt ourselves to our environment is the greatest mistake in discussing the present problem "So free we seem, so fettered fast are we." "The Street of To-day" (to borrow that suggestive title) contains our dwellings, and there *we* must dwell. It has developed from a past that may be regretted as an elysium, and it may lead to a utopia, but to-day it *is*. To elaborate the metaphor, we may see the ideal woman of a bygone century beside the untrodden ways: a time of simple schooling followed naturally by the duties and affections of wife and motherhood. That home may be pictured by the streams of Dove and is as beautiful as the roses which cover its walls. At the same time, above those peaceful valleys, arose mountain heights, and there hearts wild and solitary failed to meet human love, while the spirit of their time denied them opportunities of human usefulness.

The girl of to-day finds herself looking out upon a scene of great activity. For war, for work, and for existence, men, women and children throng the streets. The call to join them is imperative. She sees—

"The good want power—
The powerful goodness want;
The wise want love, and those who love want wisdom;
And all best things are thus confused to ill.
Many are strong and rich, and would be just,
But live among their suffering fellow-men
As if none felt: they know not what they do."

What is her position? During childhood and girlhood she has had an amount of personal and intellectual freedom unknown to our grandmothers, but her education has equipped her for no definite duty in life. Her natural instincts of possession and protection would spend themselves upon her home and children, and it is a matter of common knowledge that for an increasingly large number of middle class women there is no prospect of marriage, so an alternative must be provided. The wisest of mothers cannot offer house-keeping scope sufficient for several daughters, and after girlhood a woman should not be entirely dependent upon the most devoted father for pocket money and thus kept in entire ignorance of the economic stress of the outside world. There are those who cry "motherhood for all women," forgetful that in Western lands motherhood is only acceptable in the terms of marriage as we know it to-day. Vox populi, vox Dei is, in this connection, engraved on stone. The transition from high school and college to a condition of Purdah is unthinkable, and neither is our "Street" situated in Utah.

G. H. F. G., if he will pardon the criticism, sees too easy a solution. The Republic of Plato would allot to women definite duties and ways of life, his state employing the woman physically best fitted to bear and rear *its* children, but in these things a thousand years are but as one day and are very far, as yet, from entering into our calculations, and the fact that an excellent tenpenny edition can be procured of the scheme has not even advanced its popularity outside the convent walls.

No woman can decide if her life shall be one of motherhood or social service and economic independence. *She must be prepared for both.*

"Was it something said . . .
. . . was it touch of hand,
Turn of head?
Strange! that very way
Love began."

Our difficulties and yet our joys in life come from our dual nature, and the things of the spirit are stronger far than any material considerations. Lo, here; lo, there, and a world is counted well lost

Some fear that education and independence will put marriage at a discount. They need not; the Ideal Home will always come before a career; when they can be combined it is, indeed, a triumph.

The unmarried woman does not ask for pity; she is greatly developing her opportunities, and, given understanding and more social freedom, they are unlimited, and while there is the present appalling loss of infant life it would appear unnecessary to bemoan the child that can never be. As true woman she is wanted everywhere, and the cry of the children is for her to help and to save. Given a sound economic basis, a working and intense interest in life, there is a whole world awaiting her mother-love—which is service.—Yours, etc., S.

SIR,—Permit me, through your columns, to protest against the publication in the GUY'S HOSPITAL GAZETTE of such poems as that entitled "The Puritan and Softy," which appears in your issue of February 12th.

Without wishing to interfere with any man's political convictions, and whilst sympathising with your difficulty in obtaining "copy," I can assure both you and the writer of the poem that there are many Guy's men at present enduring the strain and burden of the winter campaign in the trenches to whom the publication of such vulgar and childish verses is very offensive. Life out here is hard enough without having one's ideals of one's old hospital shaken by such puerility.—I am, Sir, yours aithfully, B.

Northern France,
15th February, 1916.

DEAR MR. EDITOR.—In reply to your application for "copy" I venture to send you a few anecdotes of life "somewhere on the East Coast." The Regiment is stationed in a seaside town which is the home of a curious medley of infantrymen, artillerymen, airmen, mine-sweepers, and old women. As we all meet in a local tavern quaint tales are exchanged by members of the sister services. The following are a few that I remember. Every day ships entering the harbour are required to exchange signals which are changed daily. One night a boat coming into the harbour omitted to give the signal, and the artillery officer on duty according to orders fired two shots across her bows, whereupon the skipper of the trawler ceased woolgathering and showed the correct lights. The humour of the situation lies in the fact that the artillery officer's leave was stopped for six months because the noise of the firing woke up the crusty old major in command of the fort.

A subaltern on leave sent a wire to a brother officer asking the old gag, "Have you seen Amos?" The recipient sent back the reply, "Beware of Amos, he is a spy spreading malaria germs." The Intelligence Department having in vain made exhaustive inquiries as to the identity of Amos, sent down an official to interview the sender of the telegram, and on asking who is Amos, was not a little disgusted to be told a-mosquito.

At the beginning of the War airmen were very nervous of flying over fortified areas, as the gunners used to range their guns on them and fire, and then send them a polite note asking for details of their marksmanship. Our airmen soon grew cunning, told the gunners that they had overestimated the range by 500 yards, thus ensuring that future shells would burst 500 yards beneath them. All went well until an aviator from one of our other flying stations flew over the garrison, and on receipt of the note, replied that he was quite unaware that he was being fired at, thus at the same time spoiling both the game and the gunner's temper. A submarine miner in charge of a minefield, indiscreetly disclosed his intention of blowing his minefield up the day peace was declared: rumour has it that when the Naval Authorities heard of his intention they banished him to a lonely rock in the North Sea and he is now training seagulls to settle on the periscopes of hostile submarines and thus help to foil Germany's submarine menace. Occasionally, cargoes of ships that are mined are washed ashore—a minesweeper skipper rescued a case of "dutch drops" and proceeded to present all his friends with a bottle of "dutch drops;" as the "drops" contain sulphur, the result had better be left to the imagination.

Late one night the M.O. was fetched by a rather hilarious messenger to attend to a man who was alleged to have hanged himself, and who had been cut down and was being subjected to artificial respiration—further investigation revealed the fact that the patient was a stuffed khaki dummy used for bayonet practice. A corporal in charge of the sick was told to apply a mustard plaster for thirty minutes to the back of a man who was complaining of pain in that region. After thirty minutes had elasped it was found that the corporal's hand was blistered and the man still suffered acute pain in his back—one wonders whether the Derby recruits have unusually tough skins, or whether the corporal had an unusually thick head and had applied the mustard plaster in a novel fashion. Subsequent to a Zep. visit, an old lady at one of the local boarding houses was enjoying an early nap—the maid not knowing the old lady had gone to bed—dumped a hot water-bottle on the old lady's chest. The old lady screamed "Zeppelins" and hurled the imaginary bomb away from her. A man was confined to the guard room, and being tired of life decided to commit suicide by taking chloride of lime. To make doubly sure he swallowed the contents of an emergency bottle, kept for use in case poisonous bombs were dropped by hostile aircraft. The solution in the bottle was carbonate of soda, and rumour has it that the victim had the appearance of a hoven sheep. A cross-eyed sergeant-major was detailed to destroy a horse. As he raised his rifle to his shoulder—the orderly holding the horse cried "D'yer shoot, where yer looking yer honour?" On being answered in the affirmative he exclaimed "Then begorra come hold the blooming hoss yerself." . . . . . .

I hope you will censor any portions of this letter not suitable for publication, as I do not wish that either you or I should follow the example of the *Bystander* and be fined £50. I remain,

AN OLD GUY'S.

[We have reluctantly done as requested by our correspondent in his last paragraph.—ED.]

Papers by Guy's Men.

A. P. Allan, M.D., B.S.: Phantom tumours.—*Clinical Journal*, February 9th.

W. M. Mollison, M.C.: Case of carcinoma of the superior maxilla, with secondary glands in the neck; no recurrence after two years.—Sarcoma of the ethmoid: Operation.—Sarcoma of the tonsil (?); mass of glands in neck; removal of tonsil.—*Proceedings of the Royal Society of Medicine*, January, 1916.

P. P. Cole, M.B., Ch.B., F.R.C.S., L.D.S. Eng., and C. H. Bubb, L.D.S., R.C.S. Eng.: Deformities of the jaw resulting from operation or injury—*B. M. J.*, February 19th, 1916.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

The Hyper-Hypodermic.

"Gold Hypodermic Pocket-case. Contains a patent Solid Gold Hypodermic Syringe (min. 20) with two gold-mounted platino-iridium needles, two capped and stoppered bottles, mortar and pestle, one tube of mercuric potassium iodide, and 15 tubes of hypodermic products in hinged rack. In Solid Gold, exquisitely wrought. Price £90."—From a Catalogue.

Who buys this sumptuous engine, I wonder? Is it, perhaps, subscribed for by "a large circle of grateful friends and patients" and presented to Dr. X. on his retirement from practice "as a small token of their affection and esteem"? If so, we may be sure it takes its place among the family plate, and is never more used by the good doctor, whose ancient, doubtfully-aseptic, three-and-sixpenny syringes have brought morphia and relief to so many sufferers.

Or is it bought by a rich and doting aunt for the favourite nephew just starting on his "chemistry and bi."? He wonders what the deuce is the use of it, thanks his aunt very much, and later in his career finds it an eminently pawnable article. Is it scheduled by the War Office (Form Z.00009) as part of the necessary equipment for each ward in all military hospitals? Or, again, does some rising general practitioner say to his wife at Christmas, "My dear, I've had three hundred new panel patients this year. I think I can afford that hypodermic syringe we were looking at."

"In Solid Gold, exquisitely wrought, Price £90." No, this is an instrument for potentates and Park-laners. From such a syringe, we may imagine, does the millionaire receive his mercuric injections. A Kaiser's Court Physician, perhaps, soothes his master's jaded nerves with this hypodermic *de luxe*, until his country's need for gold becomes urgent, when a mere affair of steel and glass must suffice.

Once upon a time the doctor's gold-headed cane was a most important factor in his best professional manner. Merely resting his chin on the gold knob, apparently, gave great weight to his opinions; as you may see satirized in Hogarth's plate. Later, the physician's gold-rimmed *pince-nez*, adroitly handled, have been supposed to win him kudos and guineas, and to have hall-marked his prognoses. Does he now create a favourable impression by producing this precious hypodermic from an inner pocket, a hollow needle being the only instrument which he-who-is-not-a-surgeon may push through his patient's skin. But can he condescend to inject ordinary morphia from such an instrument? As well drink ginger-beer from exquisitely cut champagne glasses! This Midas among physicians should banish from his pharmacopœia everything common or unclean, and prescribe only musk, gold and platinum salts, or that preparation of powdered rubies which helped to aggravate the discomforts of Charles II.'s deathbed.

The man who possesses this superlative syringe has his work cut out to live up to it. If any charitably disposed person should think of giving me one, I hereby give notice that I would prefer to have an ordinary ward hypodermic and £89 16s. 6d. in cash.

A. N. C.

Reviews, etc.

A Manual of Surgical Anæsthesia. By H. Bellamy Gardner. (Baillière, Tindall & Cox, 8, Henrietta St., Covent Garden.) Price 7s. 6d. net.

The second edition of this clearly written work is modelled on the same lines as that of 1909, and such alterations as have been made tend greatly to assist the student or practitioner in obtaining a clear insight to the principles of anæsthetic administration.

The subject is most systematically discussed, commencing with general choice and advisability of anæsthetics, after which each method and form is concisely described and illustrated. Much of the newer apparatus seems to lose its intricacy and mystery under the able explanations given, and these paragraphs should prove of great value to the many who have seen the administration, but lacked the opportunity of personal trial.

Sequences, emergencies, and preparations are all treated in the same concise style, and we feel that the work, carefully read and appreciated, should prove of the greatest use to all whose early or late interests lead them to the subject discussed.

Wheeler's Handbook of Medicine. By W. R. Jack. 5th edition. (E. & S. Livingstone, Edinburgh.)

This well-known little text-book has retained, in its present edition, all its essential utility and conciseness, and at the same time been brought as far as possible up to date. As explained in the preface, some of the most notable advance in study and diagnosis of disease have been made possible by newer methods of cardiac investigation, and the corresponding chapters have been most efficiently revised.

Recent developments in treatment have been duly explained and inserted, while the whole work has been carefully keyed up admirably to represent a summary of medicine as our knowledge stands at the present day.

BOOKS, &c., RECEIVED.—The Middlesex Hospital Journal, The Nursing Times, The Hospital, The British Journal of Nursing, St. Bartholomew's Hospital Journal, The Hospital Gazette, St. Mary's Hospital Gazette.

Rugby Football.

GUY'S v. MOTOR MACHINE GUN SERVICE (BISLEY).

With a weaker side than usual out, it was thought that the Service might again defeat us at Honor Oak Park on the 29th of January, but we managed to win by quite a respectable margin, although the try gained when Cowan was injured and the subsequent goal was, of course, a gift. Our opponents started in good style, getting the ball from the scrums and using their feet well, but a great change came over the game when Micklem and Thomas handled well and gave up to Curle who made a fine dash for the first try. Reitz did not convert, but just after he kicked a splendid dropped goal, to be followed almost at once by a useful sprint on Davies' part and a try rather far out. Harrington, who had been doing much useful work, came further into the picture with an attempt at a dropped goal.

Ends were now changed, and misfortune at once overtook the visitors, Lieutenant Cowan sustaining a dislocated jaw. When he was knocked out, the Service men all stopped playing, so Reitz ran in and beneath the posts unopposed. Cowan's injury was successfully attended to by Dr. Bundey and Surg. L. B. Stringer, R.N. The Lieutenant is a Canadian and a good player, the fact that he was wounded in South Africa during the Boer War and again very severely with P.P.L.I. in France, and is now playing well, speaks for his fitness and sportsmanship. Playing one short the Gunners were by no means done with, and by sheer determination they got an unconverted try, but that was all their score amounted to. Guy's put on another three points, Shellswell ending up a fine dribble by picking up and going for the line. Reitz's kick just missed. Splendidly Guy's three-quarters worked to Davies, who ran well till, just as a try looked certain, cramp caused him to collapse. The halves were afflicted with inability to pass the ball breast high, many of their passes being almost subterranean. Final score—Guy's, 1 goal, 1 dropped goal, 3 tries (18 points); M. M. Gun Section, 1 try (3 points. Team :—

J. S. Forbes (back); C. L. Curle, C. M. Thomas, A. W. A. Davies, F. J. Harrington (three-quarters); T. E. Micklem, C. C. Becker (halves); G. E. Kidman, C. W. W. Armstrong, F. W. Reitz, J. L. Gie, J. Shellswell, T. L. Heath, E. A. Phillips, C. Caldicott (forwards).

GUY'S v. ST. BARTHOLOMEW'S.

For the first time since about the seventies or eighties we played a friendly with Bart.'s on the home ground on February 5th, and a splendid game it was, too, though, to be quite fair, the better side won. They had the legs of us and were quicker on the ball. Thomas was not exactly smart on the ball, although he was scarcely to blame when Wilson beat him and ran in for the first try. We have developed a tendency to go high in the tackle, and also to pass the ball standing still, and when defending we hang on too long instead of punting for touch. After Evans had missed the goal from Wilson's try, Guy's three-quarters got moving to good effect, and Reitz, lying handy, ran in for a nice try which Medlock did not add to. Then Llewellyn showed a clean pair of heels and scored well by the uprights for Evans to do the needful. Against wind and sun Guy's were not at all happy. Knott and Medlock tried a drop, and Becker sprinted well for the line, but he hadn't quite enough pace and was tackled. From the scrum Eberli got away with the ball at his feet, and toeing it into play instead of to touch, he got possession and gained a try which he well deserved. Evans just missed the extra points, half-time giving a welcome breather to all, as the game was very fast.

Phillips played well all the afternoon, and on resuming, he dribbled cleverly for Knott, who was lying handy, to score. No conversion followed. Llewellyn, for Bart.'s, developing much pace and swerve, occupied us with defence for a bit, until Eberli broke away and went on to score against the posts, Evans easily majorising. Now came a little bit of good fortune, but it is always on the cards when points down and when you have a good following wind. Medlock punted high, and the Guy's men following up smartly in the extreme, charged down the full back's kick, Kendall getting the first try, and a similar manœuvre let in Reitz just afterwards. Reitz's try was added to by Medlock, but the other one was too wide to do anything with. Guy's tried their utmost to get another score, but no further points accrued to either side. Final score—Bart.'s, 2 goals, 2 tries (16 points); Guy's, 1 goal, 3 tries (14 points). Team :—

G. M. Thomas (back); F. A. Knott, N. Kendall, E. A. Leviseur, C. L. Curle (three-quarters); C. H. Medlock, C. C. Becker (halves); G. E. Kidman, F. W. Reitz, C. W. W. Armstrong, J. L. Gie, T. L. Heath, E. A. Phillips, C. A. Bennett, C. Caldicott (forwards).

GUY'S v. M. T. CATFORD.

It was a bitter afternoon at Honor Oak Park for this match, on February 9th, and, being a Wednesday, very few spectators were present. Candidly they did not miss much, for the game was almost entirely confined to the forwards, and the ground being heavy the majority of them spent the afternoon on the ground.

We won by the narrow margin of 1 try (3 points) to nothing. The try was gained by Hawes, and the attempt at conversion by Reitz. These three points were obtained early in the first half, and beyond them nothing

was scored. The remainder of the game was devoid of incident, and practically developed into close footwork up and down the field, the backs having a look in when luck favoured them with a glimpse of the ball. Team:

P. G. McEvedy (back); F. A. Knott, N. E. Kendall, E. A. Leviseur, C. L. Curle (three-quarters); C. H. Medlock, C. C. Becker (halves); G. E. Kidman, C. W. W. Armstrong, F. W. Reitz, J. L. Gie, E. S. Phillips, E. S. Hawes, T. L. Heath, C. C. Bennett.

GUY'S v. ARTISTS RIFLES.

Played on our own ground on Saturday, February 12th. The Artists came along with a nippy side, very fast behind the scrum and very much on the ball; just at first it looked as if Guy's were in for a warm time. The game developed into a very fast one, the running on both sides being particularly good. We forced a minor, but were soon rushed back, and Donaldson ran in for our opponents with a good try. Jennings did not manage to convert though it was a good attempt. R. V. Knight, who was making a first appearance for us, then came along with some good runs, from one of which Phillips received and sailed over for three points to which Reitz added a useful 2 more. A grand run by Cartwright, a very fast centre playing for the Artists, ended in his getting right through single handed. No conversion followed. The first half ending with Curle sailing right up to the Artists back and then electing to kick instead of hanging on for a swerve. The ball was cleared and half time taken, Guy's being one point down.

The second half opened with a miskick from Becker, which rather let our opponents up. Becker is a little unfortunate this way. Then Knight marked cleverly, Reitz's excellent shot going just outside, but just after Curle went through in his best style with a really spendid try. Phillips got off from a line out, and Reitz receiving ran on for another. Reitz missed both kicks, the first one (from Curle's try) hitting the post. To finish up with Knight put on 4 points by dropping a neat left foot goal. Final score—Guy's (1 goal, 1 dropped goal, 2 tries, 15 points): Artists (2 tries, 6 points). Team:—

P. J. McEvedy (back); C. L. Curle, R. V. Knight, F. J. Harrington, F. A. Knott (three-quarters); T. E. Micklem, C. C. Leviseur (halves); G. E. Kidman, C. W. W. Armstrong, F. W. Reitz, A. W. A. Davies, J. L. Gie, E. A. Phillips, T. L. Heath, E. S. Hawes.

GUY'S v. M. T. GROVE PARK.

The Grove Park Soldiers paid their return visit to Honor Oak Park, on Saturday, February 19th, and found us with a very depleted side. It was only by Curle looking up every available man that the fifteen was at last completed. It was not a good game, or one that could by any means be called enjoyable. Too much scrapping and too many questionable tactics.

We were beaten by 18 points to 5, 3 goals and 1 try to 1 goal. But without wishing to excuse, it is sufficient to note absentees—Curle (due for an exam.), Medlock, Knott, Kendall, Reitz, and Harrington. All more or less unfit. Great credit is due to those men who filled the breach and did their best. Guy's were soon 5 points down. Nixon got in for a try quite early, and a splendid conversion by Major Laird followed. A feat the Major again succeeded with, after Clark had got another try for the Motor Transport.

Our forwards were playing well, especially Kidman, who did the work of several, and the others, notably Armstrong, Phillips, and Hawes backed him up well. But soon there were only 7 of them, as Shellswell was taken out to replace Davies (injured) at three-quarter. In this position Shellswell got a good try, well led up to by Knight, who converted the same.

After half-time we did badly and had to defend most of the time, in which branch McEvedy, Leviseur and Micklem did well. Knight had to hobble around with a strained leg. The visitors got two more tries, both by Brown, Laird converting one, and this made up the total score. Millet was unable to referee, so H. N. Eccles very kindly deputised. Team:—

P. G. McEvedy (back); A. W. A. Davies, R. V. Knight, C. C. Becker, G. W. Allen (three-quarters); E. A. Leviseur, T. E. Micklem (halves); G. E. Kidman, C. W. W. Armstrong, J. S. Shellswell, J. G. Gie, A. W. Hawes, E. A. Phillips, C. C. Bennett, F. Long (forwards).

Births.

FRASER.—On the 12th February, at Shooters Hill Road, Blackheath, S.E., to Dr. and Mrs. A. Fraser—a son.

OGILVIE.—On February 5th, 1916, at 32, Cyril Mansions, Battersea Park, to Mr. and Mrs. Heneage Ogilvie—a son.

PARRY-PRICE.—On the 21st February, at Castle Hill, Reading, the wife (*née* Elsie Bevan) of Hoel Parry-Price, Surgeon, Royal Navy—of a son.

Marriages.

ALCOCK—EARLE.—On the 10th February, at All Saints' Church, West Southbourne, by the Rev. G. H. Bateman, Arnold Alcock, M.B., B.S., of Gloucester, son of the late John Alcock, J.P., M.R.C.S., of Burslem, and Mrs. Alcock, of May Bank, Stoke-on-Trent, to Dorothy, younger daughter of Mr. and Mrs. Richard Earle, of Bournemouth.

KNOTT—THOMAS.—On the 18th February, at St. Phillips, Kensington, Frank Alexander Knott, of Guy's Hospital, only son of Mr. and Mrs. John Knott, of Eddington, Canterbury, to Dorothy, only daughter of Mr. and Mrs. Grosvenor Thomas, of St. Anne's, Leonard Place, Kensington.

WILLS—WACHER.—At St. Matthew's Church, Denmark Hill, S.E., Alfred Wills, to Emma Florence Wacher.

C. H. M.

GUY'S HOSPITAL GAZETTE.

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Passim.

TAKING the editorial pen in our firmest grasp, and drawing hazy inspiration from our pipe with the largest bowl, we set out on the seeming light, fantastic task of mirroring the hospital facts and fancies of the past few hours. Our expression shows an absolute content and determination, for are we not, one and all, soldiers sworn?

At length our problem is solved and our minds can indulge in *delicious* repose and reflection.

Then slowly the element of contentment fades, the pen encounters the covering of the editorial cranium in a few spasmodic, oscillating movements, and is laid gently down. More smoke, in clouds, emerges from that largest bowl, and in a gathering oblivion the weighty truth comes home to us. Our subject is exhausted. The last word has been spoken, the last critic heard—and we are soldiers!

No more can we advise and suggest, conjecture and discuss. We stand with an outlook so wide, yet so perfectly defined and proportioned around one chief centre, our duty in this war, that it needs neither comment nor description.

At this conclusion willingly the pen resumes its essential obliquity, the smoke-clouds drift slowly aloft, and we decide, once and for all, to be rid of an argument so often bringing us dangerously near to conflict with national interests.

In the closing of this second year of the tempest we see returning to us some few of the men who answered the immediate call, and right sincerely we welcome them home. May they be the forerunners of many more. But some few months and they will be ready to again follow the medical paths which they had so suddenly to leave, and we have then but to step into their places and they into ours.

So may the question be answered, and so, we hope, when peace once more comes to us, may it be said that Guy's have done their duty.

THIS morning, as we write, there is a strange silence in the Boro'. It has a quaint and old-fasioned look. The struggling horse vehicles, the motor buses, and even the few taxis, all white with snow, vaguely seem to belong to the days of Dickens rather than our own. Our park and footways show as an intricate patchwork of deep brown and brilliant white, and each gable, ledge and cornice of the hospital buildings supports a snowy covering.

It is not often that Guy's is snowbound on Shrove Tuesday, but the present indecision of the weather seems quite in accord with the greater happenings of these days.

WE read with regret of the death in India of Lieut. W. H. Nicholls, R.A.M.C. He entered Guy's from Bradfield College in 1910, and qualified in 1914. He will be well remembered and his loss deeply felt by all who knew him.

WE have been asked to state that copies of the new Guy's Hospital Pharmacopœia can now be obtained from Messrs. Grattan, of Boro' High Street, Mr. Croucher, in the Medical School Office, Mr. Williamson, in the Dispensary, and Miss Smith, in the Matron's Office. The charges are—2s. in cloth, 2s. 6d. in leather, postage 3d. extra; 3s. in leather, interleaved, postage 4d. extra.

A LITTLE story of Guy's afield:—

A sailor named Hart had been operated upon, in the morning, for the removal of a sequestrum from a wound in the gluteal region.

That evening, as the Medical Officer was "going round," the following was overheard:—

Night Sister to M.O.: "Please could you leave something for Number 43, as he has got such terrible pain."

M.O.: "Hart?"

Night Sister: "Oh, no! Buttock-wound!"

OUR thanks are due to the readers who responded to our call for contributions. Articles, letters, and even highly interesting photographs have reached us. May we hope that more will soon be in the post, if not already on their way?

IT is cheering to hear the improved reports coming from the College dining-room, and in the hands of the Aerated Bread Company the catering seems to be decidedly improved It is a pity that more men do not patronize the College for dinner at night, since numbers so obviously improve the possibility of a variety in the menu, and we would suggest that the present conditions are fully deserving of a trial.

ANSWERS TO CORRESPONDENTS.

"Humble Apologies."—Accepted.

"O.V.B."—They have baked you too brown. You must sugar your hair.

Common-sense Eugenics.

I.

In early times it is probable, as Spencer and others have shown, that war was one of those forms of the struggle for existence which led to the survival of the fittest. In personal immediate physical conflict between body and body, that which is stronger, more enduring, better equipped, will survive and breed its like. A serious and substantial case can thus be made out for the value of primitive warfare, on racial grounds, to say nothing here of the sociological grounds held by Spencer when he shows how warfare increases the size of social aggregates, and ensures freedom from fighting, to a degree and for periods which are indispensable conditions of high social and notably æsthetic, organization and advance.

The case is far other when, as in historic times, the physically and, generally speaking, morally best of a nation's young manhood are chosen to wage its battles. Long before the modern advocacy of eugenics by Galton and the systematic study of human heredity throughout the world of science, perspicuous writers, seeing through the smoke of immediate events to their far consequences, have taught that such a method of warfare involves what nowadays we call "reversed selection," exactly the opposite in principle and consequence to that which was described in my first paragraph. We all find reasons for the fall of the Roman Empire according to our creeds, instincts, and prejudices. But some of the reasons advanced have actually reason in them, and there is much to be said for the theory that the incessant drain of the right stuff in the military sense from the population of Rome led, in the long run, to the production of that degenerate people who wished only for *panem et circenses*. The recruiting officer rejected the halt and the blind, the feeble kneed, the easily fatigued, saying, though he did not know it, "You are not good enough to be a Roman soldier, stay at home and be a Roman father." The future was ruthlessly sacrificed by militarism to the present, even as now in Northern Europe.

Arguments of this order involve the important assumption that the qualities for which the would-be soldiers are chosen to be killed, or rejected to breed, are inherited. We know that in general that is so. Professor Karl Pearson's careful observations on the heredity of stature, for instance, come in our own decade most signally to strengthen the observation of Michelet, the historian, that the Napoleonic campaigns had lopped a cubit off the stature of Frenchmen. That assertion must not be taken too literally in the absence of the necessary data, but it expresses a general truth which entirely warrants the remark of Prof. J. Arthur Thompson that not even the discoveries of Pasteur—which, as Huxley remarked, sufficed to pay the whole indemnity after the Franco-

Prussian war—could restore the physique which the victories of Napoleon's armies had destroyed.

Every week's casualty lists contain the names of one or more British athletes who have fallen in France. They may have been winning or losing, retreating or advancing, but they are dead, and Britain will have no more sons of theirs. "Wars are not paid for in war times: the bill comes later," said Benjamin Franklin, and it is this deferred payment for losses incurred, which makes the actual losses on the field of battle the least part of the price paid for victory or defeat. Beside the destruction of the strong we must put the propagation of the weak, a force counter to eugenics—call it, if you like, the dysgenics of war—whose effects as racial consequences are disastrous enough. On the resultant, then, of these two forces, the one aiming at the multiplication of the strong, the other at their destruction, depends the social history of Europe for the next hundred years or so. And since we all know a good deal of the ravages of the latter, it may not, perhaps, be amiss to consider briefly the latest teachings of the exponents of eugenics.

The founder of modern eugenics was Sir Francis Galton (1822—1911) who, in his book Hereditary Genius (1869), sought to show that many kinds of human ability are inherited, that a talent for art, music, letters, tended to recur in certain strains, and to draw certain practical conclusions therefrom. Practically the aims of the present day eugenists have changed little since Galton's time, though the field of investigation, and with it the data accumulated, has enlarged enormously. The following paragraph contains the essence of his teaching as well as that of contemporary eugenics:—

"The best form of civilisation in respect to the improvement of the race would be one in which society was not costly; where incomes were chiefly derived from professional sources, and not much through inheritance; where every lad had a chance of showing his abilities, and, if highly gifted, was enabled to achieve a first-class education and entrance into professional life, by the liberal help of exhibitions and scholarships which he had gained in early youth; whose marriage was held in as high honour as in ancient Jewish times; where the pride of race was encouraged (of course, I do not refer to the nonsensical sentiment of the present day that goes under that name); where the weak could find a welcome and a refuge in celibate monasteries or sisterhoods; and lastly, where the better sort of emigrants and refugees from other lands were invited and welcomed, and their descendants naturalized."

It was not, however, till 1883 that Galton, in his "Inquiries into Human Faculty," introduced the word eugenics, adding the following explanatory note:—"That is, with questions bearing on what is termed in Greek *eugenes*, namely, good in stock, hereditarily endowed with noble qualities. This and the allied words *eugeneia*, etc., are equally applicable to men, brutes, and plants. We greatly want a brief word to express the science of improving stock, which is by no means confined to questions of judicious mating, but which, especially in the case of man, takes cognizance of all influences that tend, in however remote a degree, to give to the more suitable races or strains of blood a better chance of prevailing speedily over the less suitable than they otherwise would have had. The word *eugenics* would sufficienty express the idea; it is at least a neater word and a more generalised one than *viriculture*, which I once ventured to use."

Public interest was not aroused unfortunately, and for 20 years—until the founding of the Sociological Society—Galton turned to other work. Under their auspices, however, he again took up the subject, and in 1909 published his remarkable "Essays in Eugenics," which led to the formation in the States of the American Eugenics Record Office, which has since done valuable work. Galton's death in 1911 led to the endowment of the Chair of National Eugenics in the University of London, to which he left the bulk of his private fortune. The following year saw the first International Eugenics Congress, held in London, with remarkable success, whose work has unfortunately been interrupted by the war, in which the lead was taken by the Eugenics Education Society, of which Major Leonard Darwin has for some years been the President. In France, Germany, and in many parts of our Colonial Empire, eugenic societies exist which are—or were—in close correlation. Thus much for history.

It is unfortunate that the true aims of eugenics should have been obscured by much fruitless discussion of the inheritance of such rare anomalies as hæmophilia and night blindness, and the eternal conflict between environment and heredity. "For true eugenics," to quote Dr. Saleeby, "not merely the mating of fine germ cells, but the making of fine people, we need both nature and nurture. In fact, every living character, unless a foreign body imbedded in the tissues be ineptly so called, is the *product* and not the *sum* of nature and nurture. The concept of multiplication, not that of addition, is the true one. Here, then, the last of the 'nature *versus* nurture' nonsense." To adopt this writer's classification, we may divide eugenics into primary and secondary—or nurtural, the first comprising the care and selection of the parents, and the second that of the child from the time of conception. Tabulated they run as follows:—

Natural or Primary Eugenics.

1. *Positive.*—The encouragement of Worthy Parenthood.

2. Negative.—The discouragement of Unworthy Parenthood.

3. Preventive.—The Protection of Parenthood from the racial Poisons.

Nurtural or Secondary Eugenics.

Comprising the nurture and education of every individual from conception onwards.

Of positive eugenics, it may be said that it offers the widest scope for experimentation and conjecture, and is the branch in which least actual progress has been made. As far as our present knowledge goes, at all events, any attempt to breed genius would fail hopelessly, and within the straitest limits of the Galtonian ideal every year of genetic observation seems to render our present concepts still more inadequate. But a wider meaning may be attached to positive eugenics, with Galton's own sanction, abating our hopes of breeding genius, and perhaps resolving accordingly to take better care than heretofore of the potential genius that perishes in our midst; we may argue that, at least, we desire to encourage parenthood on the part of the worthy, even though the product be only the "average man of to-day." This is undoubtedly the truer ideal. The deathroll of the present war, for instance, as compared with that of tuberculosis, our most deadly scourge, points a striking enough moral, emphasized by the thought that tuberculosis slays only the weak. Those who appeal to the doctrine of the survival of the fittest as a vindication of aggressive war may find a refutation of it in Darwin's own words: "In every country in which a large standing army is kept up, the finest young men are taken by conscription or are enlisted. They are thus exposed to early death during war, are often tempted into vice and are prevented from marrying during the prime of life. On the other hand, the shorter and feebler men, with poor constitutions, are left at home and consequently have a much better chance of marrying and begetting their kind." (Descent of Man, chap. v., 2nd edit., 1874). This, then, is one of the problems of eugenics, others of which I hope to deal with in an ensuing article — the loss of worthy parents, the preservation of unworthy. Some talk of the economic ruin of Germany, but to read of the losses of her strong young men at this hour, though the survivors should ultimately take Paris and London, is to suspect that her racial ruin is in being too. This, in the long sequences of history, is the real Nemesis of militarism. Truly, "They that take the sword shall perish by the sword."

G. H. F. G.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the Gazette *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Obituary.

LIEUT. B. B. GOUGH,
Killed in Action.

We record with regret the death of Lieut. Bernard Bradly Gough, R.A.M.C., who was killed in action on the Western Front last week. Lieut. B. B. Gough was the second son of the late Mr. Henry Gough, barrister-at-law, of the Middle Temple, and of "Sandcroft," Redhill, and of Mrs. Mary C. Gough, of Redhill. He was a brother of Dr. Alfred Gough, of Redhill, whose wife, before her marriage, was such a prominent worker in connection with the Battlebridge Guild, which owed a great measure of its success to her initiative and untiring labours.

Lieut. Bernard Bradly Gough was born at Stockwell on September 14th, 1873, and was educated at Reigate Grammar School and at St. Andrew's, Caterham. He entered Guy's Hospital as a student in 1892, and was admitted M.R.C.S. and L.R.C.P. in 1897. He held hospital appointments at Burton-on-Trent, Wolverhampton, and Great Grimsby. After practising for a short time at Capel and Oakamoor, Staffordshire, he acquired a general practice at Compton Martin, Somerset, in 1902, where he resided until last year.

Lieut. B. B. Gough married Miss Annie S. Longstaffe, Matron of Great Grimsby Hospital, in 1900, and leaves one daughter, born in 1906. Mrs. B. B. Gough is now Commandant of the Military Hospital, Gournay Court, West Harptree, Somerset. In June, 1915, Dr. Gough obtained a commission in the R.A.M.C., and in the autumn was transferred from the R.G.A. to the Lahore British General Military Hospital at Calais. He was sent to the front early in February, and had been there little more than a week when he fell in action on Wednesday, the 16th. Particulars as to the engagement are not yet to hand.

The late gallant officer, who will be widely and sincerely mourned by a large circle of acquaintances and friends, was an ardent field naturalist and a keen observer, especially of bird life, and often conducted the excursions of the Holmesdale Natural History Club, of which he was for many years a member. The greatest sympathy has been extended to his mother and the other members of his family in their loss.

Col. Julian sends the following letter to the relatives of Lieut. Gough:—

"I deeply regret to inform you that on the evening of the 15th inst., whilst Lieut. B. B. Gough, R.A.M.C., was attending wounded in a dug-out near the trenches, a German shell fell into the dug-out and burst, instantaneously killing him and nine wounded, one of whom was an officer. He died doing his duty to his utmost in the service of his King and country, and we, his comrades, lament his loss, and offer you our sincerest sympathy in your sad bereavement. He was

at the time with the 8th Batt. South Staffordshire Regiment as their medical officer, to which battalion he had gone a few days before from the 51st Field Ambulance, in relief of a medical officer who had had to be sent to hospital ill. When found he had still a dressing and a pair of scissors in his hands. His letters and effects have been taken over by the battalion, from whom you will doubtless hear in a few days. I enclose a letter and post card which have been delivered at my office."

Lieut. F. G. Faby gives the following details of the death of Lieut. Gough :—"I arrived at the Aid Post shortly after Lieut. B. B. Gough had been killed by a shell entering the dug-out. I am sure that he did not suffer in the slightest, for death was instantaneous. He was surrounded by the soldiers whose wounds he had been dressing. In fact, the late Lieut. Gough died with a surgical dressing in one hand and a pair of scissors in the other. I still have those scissors, and they will always remind me of a noble man who died at his post. I saw a great deal of him during those terrible days, and was struck by his devotion to the poor wounded. I have thought that you would like to hear from someone who had been associated with him. His brother officers deeply regret his loss. And will you please accept my sincere sympathy for you."

Papers by Guy's Men.

R. P. Rowlands, M.S. Lond., F.R.C.S. Eng. : A case of ruptured jejunum; operation; recovery.—*The Lancet*, February 26th, 1916.

Lieut-Col. Sir Arbuthnot Lane, Bart., M.S., R.A.M.C.: The operative treatment of fractures in warfare.—*The Practitioner*, March, 1916.

Capt. Henry W. Drew, F.R.C.S., R.A.M.C.: Fractures treated by operation.—*Ibid.*

Capt. S. Wickenden, R.A.M.C.: Some notes on shrapnel-bullet wounds.—*Ibid.*

Montagu F. Hopson, L.D.S., R.C.S. Eng ; J. Lewin Payne, M.R.C.S., L.R.C.P., L.D.S.; Frank J. Pearce, L.D.S., R.C.S. Eng., D.D.S., in collaboration with Stanley P. Mummery, M.R.C.S., L.R.C.P., L.D.S.: The treatment of jaw fractures.—*The British Dental Journal*, March, 1916.

W. A. Maggs, M.R.C.S., L.D.S.: Reminiscences of student days.—*Ibid.*

Capt. G. L. Eastes, R.A.M.C. (T.F.): A sanitary section at the Front.—*Journal of the R.A.M.C.*, Feb., 1916.

Notice.

Guy's Hospital Medical and Dental Schools.

No Prize Examinations will be held, or Prizes given, during the year 1916, with the exception of the Treasurer's Gold Medals for Clinical Medicine and Clinical Surgery, and the Newland-Pedley Gold Medal for Practical Dentistry.

Guy's Hospital,
14th February, 1916.

The Position of Women.

III.

During the past three weeks quite a flattering amount of criticism has poured in upon me from quarters as diverse as the North Sea and Salisbury Plain, sufficient, indeed, to embolden me to venture upon yet a third article under this head, in which I hope to amplify one or two aspects of the problem which considerations of space forced me to leave almost untouched. The rock upon which most of my correspondents seemed to founder was that of sentimentality. In this respect, "S.'s" letter in the last Guy's Hospital Gazette was fairly typical. Romance and the Registrar General are, alas! incompatibles, and the weakness of the poets is that they leave off, as a rule, where the social theorist begins—at marriage. I have quite a nice little stock of quotations myself, and I can assure "S." that it took more self-restraint than an imperfect world will ever give me credit for not to work off a few. To those, however, who take an interest in this side of the business I commend M. Maeterlinck's quite admirable essay "On Women" in the "Treasure of the Humble," which may with advantage be followed by a course of Stendhals' "De l'amour," where they will get the views of a modern Belgian and a very old-fashioned Frenchman on the matter. The literature of Love is boundless, but most of it comes from across the Channel. Indeed, among half a score of names that spring at once to the tongue, all the novelists or philosophers who have written imperishably of Love, seem, with the exception of two or three of the first rank, to have been men of Latin blood. The French notably, and to a lesser degree the Spanish and Italians, have brought sexual psychology and self-analysis within the confines of an exact science. In England we may count Meredith, Hardy, George Gissing; Russia has to show the author of the Kreutzer Sonata and the dreamer Tchekoff; Germany has Gœthe and Schopenhauer. But turn to France, and the man in the street can reel off a string of masterpieces : *Manon Lescaut, Madame Burany, De Musset's Confessions, Mademoiselle de Maupin*, by Gautier, *Elle et Lui*, of George Sand, *La Dame aux Camelias, La Fille Elisa*, by the brothers Goncourt. Good heavens! The list is inexhaustible! But admirable, profound, witty, inspired as they all are, they yet fail to touch upon the fringe of the modern problem. The conflict of personality with personality is age long, the dawn of love perennial, but upon these hallowed topics the sociologist must not touch. They are matters for the individual solving. "Love is a religion," said Oscar Wilde, "and its ritual the most beautiful in the world." From the fields of Elysium the mundane statician is mercifully excluded!

But apart from novelists and psychology generally—deeply interesting as sex psychology is—there is, if "S." will pardon the criticism, no excuse for the

> "Was it something said . . .
> . . . was it touch of hand,
> Turn of head?
> Strange! that very way
> Love began."

type of thing. "S." knows as well as I or any other undeluded and unromantic person that the only hope for women is their economic independence. It is by fostering deliberately an unhealthy sexual precocity, and by feeding the imagination of adolescent girls with bound volumes of Whittier and Mrs. Hemans that the feminist movement finds womankind in the sorry plight it is. "It is a pity," says Mrs. Snowden, "to have dolls for girls and footballs for boys. The maternal instinct has no business to appear in a small girl child more than in a boy; it surely should not be encouraged in either during very tender years. The game of life has to be played by both girls and boys in later years, but girls, because they are girls and must be petted, indulged, excused, and controlled, are seldom taught the rules of the game. Thus is sex-consciousness ripened in the girl, making her either the victim or the martyr of someone whom she meets and touches at one point of thought and feeling only." Darwin speaks, as everyone knows, of "the lesser eagerness of the female," and it seems probable that in the evolved conditions of society prefigured in my paper, the rational education of women will have reduced the demand for maternity on the part of women to the specialised class whose function it will be to rear the nation's children. Even in comparison with present day conditions the sacrifice demanded is far from being intolerable or even unlikely. The freedom to follow untrammeled the promptings of desire is with us confined to a very few, and those far from the most enlightened, members of the community. For the bulk of the wage-earning classes their life is one of restrictions so amazing that only inertia and custom prevent their instant destruction. What, for example, is the renunciation of motherhood compared with the sacrifices demanded of a soldier in the defence of his country, of a miner, of a textile factory hand? Under conditions such as I have tried to picture existence becomes freer in a thousand ways, the possibility and demand for health and beauty come to replace a mere "will to live," a blind fever of begetting, heedless of past or future.

Make women free of men, give them a chance—in a much ridiculed phrase—to live their own lives, and there will be no modern problems. Prostitution, which spreads syphilis and kindred diseases broadcast, will disappear, for no one except a German professor is foolish enough to believe that it is anything but the pressure of necessity which drives women to the streets. We shall have no more of these "daughters of the horse-leech," with their incessant, insatiable desire for luxury and pleasure. No more shall we see young women in their flower wedded to old age and riches. Women freed from convention and economic dependence will be at liberty to develope their energies along the lines to which their natural inclinations lead them. And if all this leads to the break-up of the British home, I for one shall be happy to lend a hand in clearing away the rubbish. G. H. F. G.

Appointments.

Royal Naval Volunteer Reserve.

Staff-Surgeon H.R.H. Denny has been promoted to the rank of Fleet-Surgeon.

Royal Army Medical Corps.

Lieut.-Col. T. B. Winter is retained on the Active List, and to be supernumary.

The undermentioned temporary Lieutenants to be temporary Captains:—S. H. Browning, T. H. F. Roberts, B. R. Parmiter, T. E. Roberts, C. R. Nicholson, T. R. Trounce, C. S. L. Roberts, E. S. Marshall, N. Ackroyd, A. Scott, R. H. J. Swan.

To be temporary Lieutenants:—H. J. Gater, K. M. Nelson, A. Traill, W. O. Roberts, A. H. B. Kirkman, D. S. Steele-Perkins.

Territorial Force, R.A.M.C.

Lieut-Col. J. Young, South Midland Field Ambulance, to be Assistant Director of Medical Services, South Midland Division, with the temporary rank of Colonel, *vice* Colonel W. H. Bull.

South Midland Field Ambulance.—Lieut.-Colonel J. Young is seconded whilst holding an appointment as Assistant Director of Medical Services.

A. Alan Forty, L.D.S. Eng., temporary lieutenant, has been appointed Advisory Dental Surgeon to the Southern Area in the Northern Command.

Civil.

J. H. Mayston, M.R.C.S., L.R.C.P., has been appointed Certifying Surgeon under the Factory and Workshops Act for the Hackney District of the County of London.

Roll of Honour.

Killed.

Lieut. B. B. Gough, R.A.M.C., attached to the 8th Battalion, South Staffordshire Regiment.

Change of Address.

Capt. B. Rayne Parmiter, M.B., B.S., R.A.M.C., 32nd Field Ambulance, 10th Division, to attached 6th Royal Irish Fusiliers, 31st Infantry Brigade, 10th Division, Salonika Force.

Lieut. A. Alan Forty, from Brockton Camp, Cannock Chase, Stafford, to Military Hospital, Normanton Barracks, Derby.

W. Sampson Handley, M.D., M.S., F.R.C.S., from 12, New Cavendish Street, W., to 36, Harley Street, W. (*Tel.* 422 Mayfair).

Lieut. A. Traill, No. 2 Camp, R.A.M.C., Training Centre, Sling Salisbury.

A. E. D. Prideaux, L.D.S., R.C.S. Eng., from Ermington, to Wadham House, 50, West High St., Dorchester.

Capt. E. P. Minett, R.A.M.C. (T.), 1/6 London Field Ambulance, to 2/4 London Field Ambulance.

George H. Rodman, M.D., from Sheen Gate House, East Sheen, S.W., to 4, Heath Mansions, Putney Heath, S.W.

Three Cases of Paratyphoid Fever.

CLINICAL LECTURE BY DR. FAWCETT ON FEBRUARY 16TH, 1916.

GENTLEMEN,—I suppose some of you will shortly be going to one of the various "fronts" and for that reason I wish to impress upon you some features of paratyphoid fever. This fever, although recognised for some years, had not acquired any great importance in our eyes, nor were its characters specially brought home to us, until the period of the present war. The old and well-known typhoid fever has been effectively countered by preventive inoculation, and no serious epidemic has hitherto attacked our forces. In its place we have another enemy of the same family, but fortunately a less malignant character. At the same time it is an enemy which can create dire havoc in an army by disabling large numbers of men for a long time, and as it travels in a guise of less striking pattern than typhoid fever so it may more often escape detection. It is because of the danger which ensues owing to failure to detect mild cases that I bring this subject to your attention to-day.

Paratyphoid fever belongs to the "enteric" group: in some cases it is indistinguishable from typhoid fever clinically, but in others, and these a fair proportion, it presents differences in its clinical course to which I shall shortly refer.

Although like "typhoid" in many ways, yet there is no doubt of the essential distinction as seen in the behaviour of the paratyphoid bacilli to specific immune serums and in the cultural development on certain media. They are therefore not mere variants of the bacillus typhosus. We label the two forms Para. A and Para. B, and clinically we cannot separate the fevers to which they give rise.

I propose to use as the text of this lecture three of the few cases of "Paratyphoid" which I have seen in the past eighteen months. This lecture is purely a clinical lecture, with nothing original in it, and, indeed, a great part of the information contained in it, including confirmation of some of the points noticed in my cases, is drawn from a very valuable paper contributed to the *British Medical Journal* for November 13th, 1915, by Capt. Torrens and Lieut. Whittington, R.A.M.C., and from the discussion on the same subject at the Royal Society of Medicine on Novembef 8th, 1915, opened by Sir B. Dawson; to these sources I am therefore largely indebted for many of the facts in this lecture, as my small experience of the disease does not allow of conclusions arrived at by those fortunate enough to have dealt with a large number of cases.

To me one of the most striking features of the disease was that, although some of the cases appeared severe at first yet they soon lost that character. In the second and third week they exhibited marked improvement, especially in clearness of mind and general condition, features most unusual at so early a date in cases of typhoid fever beginning in an equally severe manner. Another point clearly brought out by the papers referred to is the lessenned liability to complications, and therefore to die, as contrasted with typhoid fever. On the other hand you must remember that paratyphoid may be as severe as any case of typhoid fever, although in these days the latter fever is not usually so serious a disease as it was thirty years ago, and only rarely do we see nowadays a case with muttering delirium, general tremor, and other evidence of a "typhoid" septicæmia.

The cases I shall bring before you are all of the Para. B type.

Para. A is well known in India, but as far as I am aware it was not seen in England or France previous to the present war: the majority of the cases met with in France have been in soldiers from India or in those of our new battalions who came into contact with them.

CASE 1.—Coxswain B., æt. 40, a mine-sweeper at Gallipoli, was admitted under my care on October 13th, 1915.

He had been damaged by concussion and bruising from a shell explosion at one of the landing places which resulted in his giving up his work. He was sent home, and on October 9th, while on the hospital ship, he had an attack of severe abdominal pain, vomiting and hiccough, apparently simulating a renal colic.

The history of his case is indefinite, but at any rate the pain was sufficiently severe to necessitate the administration of morphia. The subsequent history is as follows:—

October 11th. A rigor.

October 12th. Two rigors.

October 13th. Patient appeared to be very ill. Temperature, 103°–104° F. Tongue, dry, brown and cracked Diffuse petechial rash on back and buttocks and some on abdomen. Abdomen distended and rather tender all over. Trace of albumen in urine. Spleen not palpable. No physical signs of disease elsewhere.

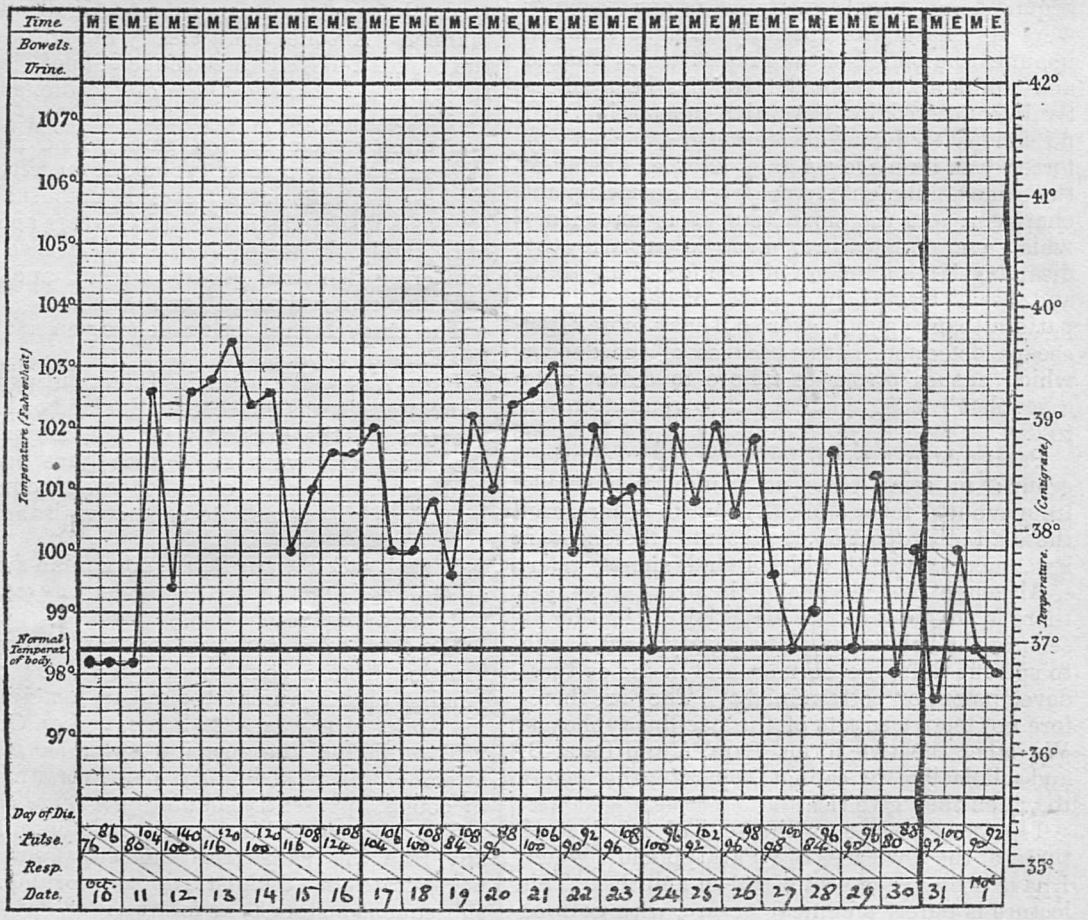
I thought he was suffering from a septicæmia of unknown origin.

October 15th. Some raised rose spots on abdomen and back, typical "typhoid spots." Petechial rash disappearing. General condition of patient distinctly improved and pulse slower.

From this date till the end of October crops of "spots" continued to appear and did not disappear until November 8th, a week after the temperature had subsided It was noticed that the spots were somewhat larger and of a deeper tint than is usual in typhoid, and that they persisted for a longer period.

CASE. I.

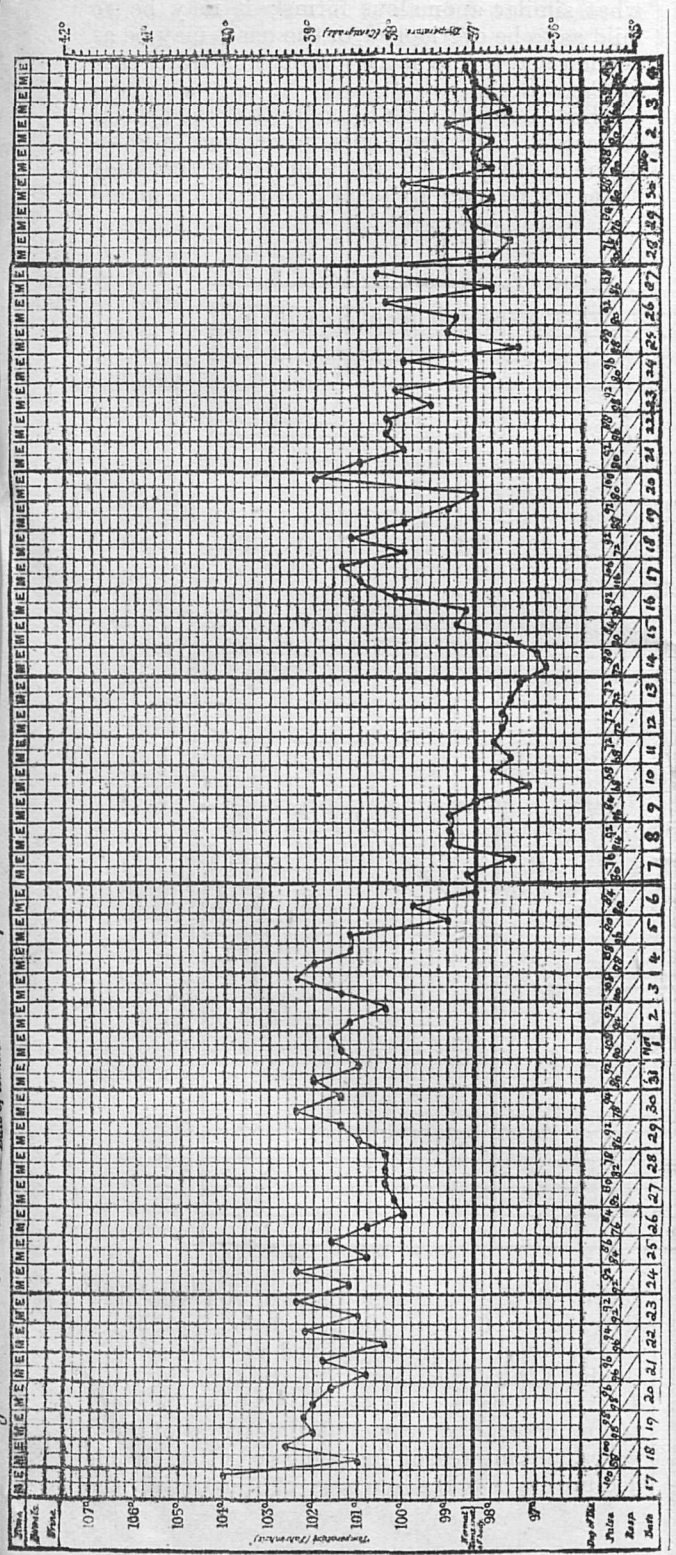
Name Private B Age 40 Date of Admission Oct. 12.



On the temperature chart, and I want you to look carefully at it, you will see that the duration of the fever was about twenty-three days, and that it was of a remittent type after about the eighth or ninth day. At the end of ten days the patient was a different being, quite clear mentally and obviously on the road to recovery, barring accidents.

Case 2.—Lieut. G. J., æt. 27, was admitted from Gallipoli, under my care, on September 27th, 1915. He had suffered with diarrhœa from August 10th, and on August 22nd, when at Mudros, he commenced to pass blood and mucus. Amœbic dysentery was diagnosed, and he was treated with emetine. After recovery from the acute attack he suffered alternately with diarrhœa and constipation.

On admission his temperature was normal and remained so, and nothing abnormal was found on examination. He was discharged on October 15th, the diarrhœa ceasing shortly after admission and the motions having become natural. Examination of fæces for amœbæ and dysentery bacilli was negative.



On the evening of the day on which he returned home he had a severe headache, and later became delirious, as also on the following evening; his temperature reached 104° F., and for the following week he was very ill. He had several attacks of shivering during the first few days.

On October 23rd he developed pain and tenderness over the region of the gall bladder. No physical signs were detected. He was readmitted under my care on November 1st. There were a few red-pink "spots" on the abdomen, and I think it was on the following day I felt the spleen below the costal margin. He did not then appear to be very ill. There was no abdominal distension, but some tenderness over gall bladder, and I thought I could feel this viscus about half an inch or so below the ribs. "Spots" continued to come out in crops; they were like "typhoid" spots, but rather larger and more prominent than usual, and of a deeper colour, as in the previous case. They persisted well into the afebrile period.

November 17th. A "relapse" occurred lasting about ten days; fresh "spots" appeared and they were still present on December 3rd. During this relapse the patient developed cystitis, but no paratyphoid organisms were recovered from the urine. In this case the onset was very sudden, and the attack at first severe. By the third week the condition of the patient was quite satisfacfory and improvement rapid.

Apart from certain points to which I shall draw your attention shortly, I want you to notice the association of this case with dysentery. It is now recognised that many dysenteric cases are contaminated with paratyphoid, and all dysenteries are now regarded as possible "paratyphoid" cases, a good many of them proving to be so.

CASE 3.—Private K. A., æt 29, was admitted from "somewhere in England" on November 23, 1915; he had not been abroad. He said that he had had a "cold," and been feeling dizzy for two or three days. On November 23rd, he felt more dizzy and shivery, and his temperature was 106° F. on admission. There were no physical signs of disease anywhere, and although he had so high a temperature yet he did not appear to be commensurately ill. His temperature chart is before you. Two days after admission he had a rigor.

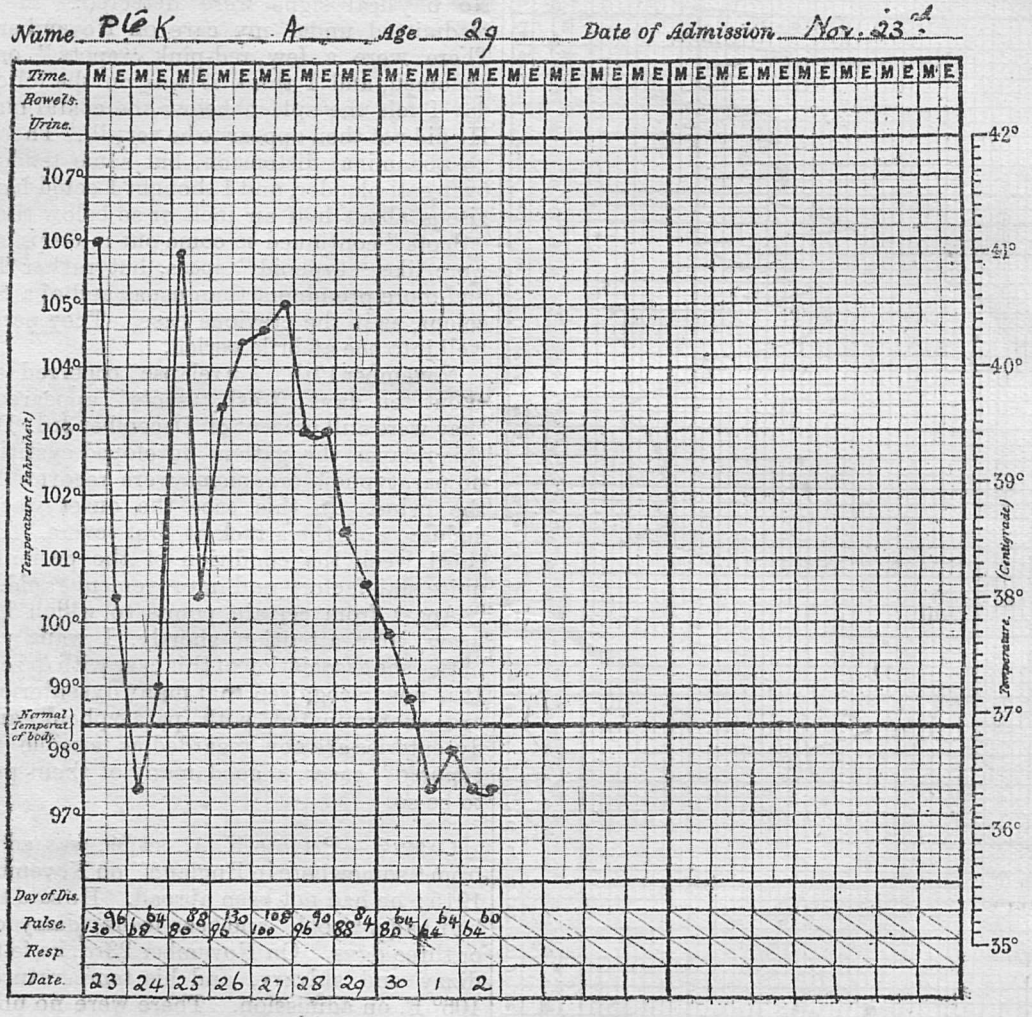
On the fifth day after admission, or the eighth of the disease, his general condition was much improved, and three days later he expressed himself as feeling quite well again.

On the ninth day of the disease "spots" were visible on the chest and back. The spleen was felt for the first time on the previous day. The "spots" persisted for eleven days after the temperature had fallen to normal, and the spleen was still palpable. This case then was acute, of short duration, and quite unlike typhoid fever, although it was recognised ultimately as belonging to this group by the crops of spots, the palpable spleen, and later by the cultivation of the Para. B bacillus. You may imagine to what various diseases the fever was attributed until the "spots" and enlargement of the spleen appeared.

In passing, I would remind you that genuine typhoid fever at times presents itself in somewhat similar anomalous forms; it may be so mild as to be overlooked, or the onset may be as sudden and severe as it was in this third case of Para. B.

Thus, I do not wish to imply that the special features I have mentioned in relation to Paratyphoid are peculiar to it, but only that they appear to be more frequent in it than in typhoid fever. At the same time those of you who have listened carefully to the reports of these three cases would be quite justified in expressing a doubt of their relationship to the typhoid fever family. I have purposely laid stress, perhaps too much so, upon the clinical features of these cases, and my reason for doing so is that as this lecture is for the purpose of illustrating the

CASE III.



clinical course of the fever, and as this aspect is the one in which you, or most of you, will come in contact with it, I wanted to try and help you to recognise in early days the possibility of its presence. I will now pass on to consider in more detail points of interest in the symptomatology and course of the fever; the evidence, as I said before, on these points being largely drawn from the excellent papers previously referred to in the early part of this lecture.

Onset.—Please notice that in cases 1 and 2 the onset was apparently quite sudden; in the one case the man was seized with abdominal pain on board ship; in the other the patient had actually been discharged by me on the previous day, and on that same evening he developed acute symptoms, viz., delirium and high temperature. It would hardly be surprising if the friends thought we had discharged him too soon; nevertheless, remember that the man had had a normal temperature since admission and appeared to be perfectly well when I saw him last, the day before he left the hospital for the first time.

In Case 3 the onset was more gradual, and yet abrupt in the sense that on the third day he suddenly became incapacitated for duty with shivering, dizziness and a high temperature.

These cases seem to represent common modes of onset; it is less gradual, and more abrupt, than in typhoid fever.

The patients are either suddenly incapacitated in a few hours, or on the other hand they become increasingly ill for a few days, and in the end more or less instantaneously they collapse.

For example a patient has a headache, or a little abdominal pain and diarrhœa, a backache, aching of limbs for a day or two, and then, at the end of two, three or four days he feels very much worse and is quite incapable of continuing on duty.

A sudden onset is exemplified by Cases 1 and 2, and in other cases by those of men who have gone to bed apparently well, but who, on waking up next morning, complain of severe headache, of shivering, of diarrhœa, and so on, and are quite incapable of going on with their work. Even though the onset is severe, the patients do not *look* so ill as in typhoid fever, and their minds are said to be clear as a rule, and even though dull and lethargic yet they are able to give a fairly satisfactory account of the course of their illness.

Symptoms are much the same as in typhoid fever; for example the severe headache to commence with, the aching limbs and back, and diarrhœa. *Abdominal pain* is complained of in quite a large number of cases: it is moderate as a rule, but at times is accompanied by both nausea and vomiting—Abdominal pain, nausea and vomiting seem to be far more common than in typhoid fever. As regards *diarrhœa*, Capt. Torrens found it to be present in the early days in 55 per cent. of the cases. In all my cases constipation has been a troublesome feature throughout, and I gather that this is the usual sequence of events in the later stages of paratyphoid fever, even though there may have been some diarrhœa in the early stages; early diarrhœa is very rarely severe. Another symptom, a prominent one in my cases, and to me a very striking one, was the occurrence of *shivering* of a marked type, and, indeed, of what was called a true "rigor" in two of them. This is noticed in the papers referred as a peculiar feature, and I see that Capt. Torrens and his coadjutor state that it is even more frequent at the onset of Para. A fever

Temperature.—The onset is more sudden, less "ladder-like," than typhoid fever (*v.* charts). Epistaxis, cough, dizziness, deafness and sore throat form some, though a smaller, component part of the onset than in typhoid fever, and with the exception of dizziness were not met with in my cases.

During the early course of the fever the *aspect* of the patient as a rule is heavy and drowsy, except in the mildest cases, but even in this lethargic state the patient is usually not so dull as to be unable to give an account of himself, and therefore, in striking contrast with cases of typhoid fever of equally severe onset, In the mild cases, or even in those of a more severe type, as in the three cases which I have brought to your notice, the dull heavy state had passed away wholly or in part in the second week; *e.g.*, the mine-sweeper (Case 1) had begun to read the daily paper by this date, and the other patients to exhibit similar interests in a corresponding or shorter period.

With regard to the *temperature*, you will notice that it commenced to be of a remittent type during the second week, and this, I gather, is found to be the case in about 60 per cent. or more; it gives to the temperature chart a "spiky" character. This is in marked contrast to typhoid fever where the remittence of the temperature does not usually occur till a week or so later. Thus in paratyphoid fever the temperature remits earlier, and has a shorter duration, and generally by the end of the third week, or before, it is normal.

The pulse-rate is described as slow in relation to the temperature and on this account to be a sign of considerable value. As we know, this relationship is a common one in typhoid fever, but in paratyphoid it appears to be still more marked. Sir B. Dawson says that "given headache, fever and a pulse of 90 to 95, think of 'enteric.'" In the paper in the *British Medical Journal* the authors say "a temperature of 102° to 105° with a pulse of 70 is characteristic, and is more than significant of a group infection."

In the three cases I have referred to you will notice that it was only in Case 2 that the pulse-rate was slow, and even there never lower than 78 during the first week.

Spots occur at about the end of the first week, or a little later, in most of the cases. They were present in the three cases I have related to you to-day. I drew your attention to the large size and deeper tint as compared with those of typhoid fever; this feature I learn is characteristic of the "spots" of paratyphoid fever. The first case in which I saw spots they looked to be so large and red, comparatively speaking, for "typhoid spots" that I thought they were too good, and it was only on noticing that the later cases developed similar spots that we began to look upon them as normal. For this we have much to be thankful, and I hope it will prove to be a permanent feature of paratyphoid, as too often in doubtful "typhoid" cases we are uncertain whether the hoped-for "spot" is a real "typhoid spot," or not. Of these paratyphoid spots there is no doubt when once seen.

Another character for which also we should be equally grateful is the length of time during which the "spots" continue to appear and persist even after the temperature has fallen to normal, as illustrated in all my three cases. Therefore in any case in which you may suspect from the history a "typhoid" fever, do not forget to look for "spots," even though the temperature is normal, and do not forget to feel for the spleen which may be palpable for some time after the temperature has subsided. Recollect also that an enlarged spleen, just like the "spots," is as often found in the mild cases as in the severe ones.

Tongue.—The dry brown cracked tongue, such as is often seen in typhoid fever, with red tips and edges, is also frequently found in paratyphoid, and so forms a feature of value in the diagnosis. It was of this type in Case 1, but not in the other two cases.

Abdomen.—In Cases 2 and 3 there was nothing of importance to note, whereas in Case 1 the abdomen was full and like a "typhoid" abdomen. I gather from the papers referred to that the condition of the abdomen is not so suggestive as in true typhoid fever.

I have already drawn your attention to the *Spleen*, pointing out to you that it was palpable in both Cases 2 and 3, even after the temperature had reached normal, a point of special significance in relation to the diagnosis of paratyphoid fever. The spleen is stated to be enlarged to percussion, or to be palpable in 60 per cent. of cases.

I am unable to illustrate many of the complications and symptoms, but they are, for the most part, similar to those of typhoid fever, although it is said that the frequency with which they occur is very different. So far as these three cases are concerned there was a little bronchitis in one, a relapse in another in which also there was cystitis, and marked tenderness over the region of the gall bladder which, at one time, was thought to be enlarged and palpable, but it disappeared before the temperature had reached normal. From the papers I have referred to I learn that hæmorrhage is almost, if not quite, as common in Paratyphoid B. as in typhoid fever, whereas pulmonary complications, like bronchitis and bronchopneumonia are not so, and meteorism is very rare:—

Perforation of the intestine, cholecystitis, thrombosis, parotitis, are some among the many complications met with. I would call your attention specially to two peculiarities in connection with "Paratyphoid B," the first, the frequency with which ulceration is found in the large intestine, and the second, the liability to pus formation. Thus in Capt. Torrens' and Lieut. Whittington's paper it is stated that the three cases of "Para. B" in which perforation occurred were all in ulcers of the large intestine.

I have brought down for your inspection specimens from the museum of typical "typhoid" ulceration in which you will notice that ulceration is present in the large intestine, but it is so to a much slighter degree than in the small intestine.

The pus formation occurred in testes, spleen, liver and lung, and other places, and from cultivations made from the pus of several of the abscesses the Para. B bacillus was obtained.

The only other points to which I have time to refer are those of the mortality and of the method of diagnosis. In typhoid fever the mortality varies from about 5–12 per cent. in some groups of cases to 7–20 per cent. in others. In Paratyphoid, as seen in the war in France, the death rate is much lower, not more I gather

than 1–4 per cent. in Para. A and Para. B groups respectively. The conditions which have usually caused death are similiar to those in typhoid fever, viz., hæmorrhage, severe toxæmia, perforation, and, in addition, those rather curious cases of abscess formation where the lung, the spleen, and the liver were among the organs affected.

In regard to diagnosis I have tried to impress upon you the clinical aspects of the fever, the features which should raise your suspicions, and this to you is the most important point. The actual diagnosis can only be made by obtaining cultivations of the organism from the blood, the fæces, or the urine, or by means of the blood tests for the special agglutinating bodies of Paratyphoid A and B fevers.

If, however, "spots" of a typical nature have been seen and an enlarged spleen felt, then for practical purposes at any rate, the case must be regarded as belonging to the typhoid group, even if bacteriological investigations failed to give a positive result.

The Days of the Serbian Retreat.

The article which you reprinted from the *Times* about my adventures in Serbia gives one a very poor idea of the actual conditions out there, and as you are asking for contributions, I propose to outline a few days of my life immediately prior to and at the commencement of the retreat.

When we were at Pirot (in the N.E.) we heard rumours of the invasion in the north, and were forced ourselves to retreat. I was left in sole charge of all our hospital stores, etc., which had been transported as far as Krushevats (50 miles N.W. of Nish). There I was left "on my own," with a small Morriss-Oxford two-seater car, with the idea of staying there if things went well, and of retreating by the car if things went badly. It was just at this time that the Serbians began to turn against the few wretched English and French left in the country, blaming them for the non-arrival of the Allied troops. Unfortunately, I was one of these wretched ones. I was staying at a so-called hotel there, right in the middle of the town, but the rest of our hospital had retired, and were all at Salonika in safety before I had left Serbia, much less crossed Montenegro and Albania.

During the three weeks that I was in this town I saw many interesting sights: Austrian prisoners, some taken a year before, some only newly captured; Bulgarian prisoners, mostly looking filthy and unkempt; German prisoners in their helmets, looking wretched and without hope. Of these prisoners I am sure not 50 per cent. ever reached Durazzo, poor wretches! Then we had German aeroplanes, with their sinister iron cross, over us nearly every day, sometimes several times a day; and, apparently for amusement, they would drop bombs about promiscuously. As a rule, they did not do much damage, but they destroyed a huge stock of marmalade which Mrs. Stobart was hoarding up at Kraguyevats, greatly to the delight, repressed with difficulty, of the other English hospitals in Serbia, who had been without jam or marmalade for months. And once I saw a man walking about 30 yards away, when a bomb dropped and took his head clean off. Then other attractions were provided by the French aeroplanes, of which there was a station at Krushevats. I got to know the captain in charge, the Marquis de Bareinty Tholgan, and he took me up in a machine (Farman) which had been put together in 24 hours by the French mechanics, and which had not been up before. The parts were sent out from France all ready for putting together, and near the end the machines were being turned out at the rate of one a day.

I put myself under a Serbian colonel, who was in charge of all the hospitals and Red Cross work in Serbia, and he gave me his word of honour that I should be informed when it was time for me to leave the town, so I relied on that promise. I had thought that I should have to retreat directly west, to Kraljevo, so I ran over there in the small car to examine the roads. They were terrible, the mud being so bad that, although the road was practically level all the way (about 40 miles), I had to gear down to first nearly all the way. When I had proceeded about half way to Vranatchka Banya I was stopped by a gentleman who asked me, in quite good English, where I was going. I told him, and said that I wanted some water for my radiator. He told me that he had a car at the station, an ambulance car, and would I care to see it? I assented, and saw a beautiful car, but, as he explained, and as one could very well understand, it was too heavy for the roads. I chatted with him for some time, when up came Madame Grouitch, an American by birth, the wife of the Minister in England, and whom I knew. She startled me by exclaiming, "Oh, I see you have made the acquaintance of the Prince Alexis." I was a bit flabbergasted, as I am not in the habit of meeting Princes straying about the country with motor ambulance cars every time I go out for a drive. However, the Prince, to put me at my ease, said, "Well, we've been chatting comfortably for a quarter of an hour, so we'll go on talking as though we were taking a stroll down Piccadilly." This was unconventional, if you like!

I took Madame Grouitch on to Kraljevo, and on my return called at the Prince's hospital, at his request, to look over it, and to fill my tank with petrol. The hospital was a model one, as was the village

round it, thanks to the generosity of the Prince. In fact, one was struck by the contrast: a few miles away were the wretched huts of the peasants, mud-walled, earth-floored, leaky, and uncomfortable, while here were houses which would not have disgraced a town in England. And, "mirabile dictu," here were sanitary arrangements. As a rule, the Serbian has a lofty contempt for anything to do with sanitation, with the mournful result that there always seems to be an epidemic of something somewhere.

Later on, when at Cetinje (pronounced Tseteenyay), the Ambassador there, Baron de Salis, showed me a telegram that the Serbian government were offering a big reward for any news of the whereabouts of Madame Grouitch, and the Baron was very excited when I told him I had taken her to Kraljevo. Apparently she had vanished after that, and the Serbian government were afraid that she had been captured. She has done, and is still doing, a lot of propaganda work in England and America, and so is important to the government.

To go back to Krushevats, all the time I was there, every day, crowds of refugees streamed through —refugees from the north, where the fighting commenced; refugees from the east, where the Bulgarians were already wreaking their vengeance in a brutal manner on a helpless population, fired in their misdeeds by the knowledge that the Serbians loathed them as heartily as they loathed the Serbians. The refugees already showed signs of exhaustion; the shops were nearly all closed, and articles were sold at 1,000 per cent. profit. Often one was forced to give a 10 dinar (8/4) note, as one had no silver, for an article which usually sold for 50 paras (4½d.). There was a needless panic, the population not being accustomed to the notes or "bankas"; and, in spite of their being guaranteed by a million and a half of gold by a French bank, yet, as a rule, a single one dinar piece (9d.) was worth as much as a "banka."

A great many of the women and children, already exhausted by their fortnight's or three weeks' tramp, and by lack of food and shelter, stayed in this town, making food and shelter all the more difficult for those who came after them. They did not mind the Austrians—the Serbs and Austrians have always been friendly—and they heard that it was the Austrian army which was coming. Then on November 6th, a Saturday, just as it was getting dark, without any warning at all, the town was shelled by the Austrians. At least, the Germans really did the shelling with some of their big guns which they had brought into Serbia, the German gunners helping the Austrians all the time.

The town was soon in a terrible confusion, as the military had left two days previously. (With them was my friend the colonel, who had skipped off in safety himself, leaving me behind without a word of warning.) Houses were going down like nine-pins, people were rushing about the streets in panic, some only half dressed, some with freshly inflicted wounds. I did my best for the latter, but I could not get fresh supplies of bandages, etc., nor get near our stores, which were by the station, as the station was one of the places which the Germans were shelling. I waited for two and a half hours till the worst of the panic was over, expecting every moment that the "hotel" would be knocked to pieces, listening to the noise of spent shrapnel which rattled on the roofs at times. After a lull of about ten minutes I determined to clear out. I should have liked to have set fire to our stores first, but as they were nearly all medical and surgical stuff, with the exception of £1,000 worth of tents, and as it was quite probable that they had already been blown to the four winds, I played the coward and cleared out. As a matter of fact, I did not get off "scot free," as the shelling commenced again as soon as I got the car out in the streets, and I had to run the gauntlet. Luckily the car escaped undamaged, and I with only a slight flesh wound in my left hand from a shrapnel splinter. But as soon as I got out of the town I came up to a mass of screaming refugees, hysterical, panic-stricken, disorganised, and fear-mad, as well as a line of bullock wagons, three abreast, completely filling the road. I had no headlamps, only an electric torch, which I held in my right hand.

After going at a snail's pace for many hours, but leaving the crash of the explosions and the flare of houses which had caught fire behind me, my car refused to go any further. It was not engine trouble, but the rod connecting the steering of the two front wheels had got bent, so that the "near" wheel was attempting to go into the ditch on the left-hand side of the road, while the "off" wheel stubbornly refused to go to such a "low down" place as a ditch, but preferred to do a "right incline" instead. So I determined to halt for the remainder of the night—only about four hours—being then roughly eight miles from the town. In the morning, as soon as it was light, I tried to put the rod right; but although I put it right at least a dozen times, each time I proceeded only two or three yards when the wheels again took their positions, obstinately refusing to be "trained in the way they should go." Finally, I had to abandon the car, and put what baggage I had on to an ox wagon, walking myself. The animals in this wagon were nearly dead beat, and after crawling about two miles, lay down and started dying. There was I, with no means of transport, with no food but some biscuits and tabloid tea, with my baggage in a ditch at the side of the road, and the Austrians anywhere behind. On the strength of my uniform I buttonholed a police captain, and he arranged for my baggage and myself to be transported on some ammunition wagons. But after an hour's journey they turned into a field, nominally for half an hour, but it was not till five hours had passed that they moved on.

After a while I saw a Red Cross flag at the side of the road and jumped down from the wagon. It turned out to be Mrs. Stobart's field ambulance, and I obtained her leave to go with them for a few days. So I had to hurry on to get my baggage off the different wagons. In doing so some of my kit disappeared as I had to range up and down the road in search of the wagons, which were separated by other wagons. About ten minutes after I had transferred my baggage we had orders to move on, so on we went. There were six motor ambulances (Ford cars) as well as a number of bullock-wagons, and there were two doctors, nurses, orderlies, and chauffeurs. I was with them for a week, and wishing to make mayself useful I usually sat in the front car, jumping out every ten minutes to "shove." It is remarkable how tired one can get from "shoving," especially when one has to stand in mud, sometimes far above one's knees. I recommend this to anyone keen on "rugger" as one of the finest "scrum" exercises yet invented; and there was always the probability of the back wheel, after stubbonly refusing to move, suddenly flying round at a tremendous pace and splashing everyone, without regard to person or "place," who happened to be anywhere near. Once a dog tried to bite the back tyre as it was furiously revolving while the car remained at a standstill! I think I am correct in adding that the dog could not bite anything harder than water for many days. I only hope that the dog escaped the general slaughter of animals by the Serbs in their terrible famine, and that he is still at large to try conclusions with the Austrians and Germans! V. D.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

"The Position of Women."

SIR,—In his important and most interesting articles on "The Position of Women," G. H. F. G. makes the implication that the employment of married women in factories is one of the most substantial causes of the high rate of infantile mortality which prevails in the northern industrial centres. There is, of course, every *a priori* reason for thinking that the absence of the mother from home for the best part of each day must be to the prejudice of young children, but there are also grounds for believing that factory work for women is not the whole cause of the awful death rates of Lancashire and Durham and that the undoubted evils of the system may be materially reduced without cutting off the extra income which, after all, means plenty of food. If the areas of grossly excessive infantile mortality are mapped out, it will be found that they correspond in a general way with coal mining—an industry in which women's work (with negligable exceptions) has ceased long since, in which wages have been at a high level for many years, and in which the homes of the workers are often practically in the open country and seldom in really horrid slums.

The special report on infantile mortality in Lancashire issued by the Local Government Board about two years ago is so interesting that my copy has been lent—and lost—but if I remember rightly the district with the highest rate there dealt with is a relatively thinly populated area with a good deal of coal mining. The same report certainly shows that the mothers of Nelson can work in cotton factories and keep the infantile death rate within limits which are almost tolerable, while in the adjoining town of Colne, industry and other conditions being apparently identical, there is the customary wastage. The facts suggest that washing the baby and keeping a high standard of general cleanliness in the house—it is here that colliers' houses so signally fail—are of the utmost importance, and there is, I think, every reason to expect that much may be done without interfering with the present industrial occupation of women to any great extent.

May I, in conclusion, express a wish that G. H. F. G. would deal more fully with the facts of infantile mortality; it is a question of numbers and has to be treated numerically.—Yours, etc.,

17, Loom Lane, Radlett. A. E. BOYCOTT.

DEAR MR. EDITOR,—As I understand, you are short of copy these days, and as one hears so much criticism and comparison of the national characteristics of the belligerent powers, I am sending you an extract from a quaint little volume published in the year 1816.

"Care to our coffin adds a nail no doubt,
But every grin, so merry, draws one out."

These two lines form the briefest of introductions; there is set before the reader a collection of "Bonmots, witticisms and smart repartees" by eminent men of the time. Among them appears the following :—

"A Picture of European Nations in Miniature."

"In religion the German is unbelieving; the Englishman devout; the Frenchman zealous and the Italian very ceremonious.—In keeping his word the German is faithful, the Englishman safe, the Frenchman giddy, the Italian cunning.—In love the German does not understand it; the Englishman loves a little here and there; the Frenchman everywhere and the Italian knows how one ought to love.—In external appearance the German is tall; the Englishman well made; the Frenchman well-looking; the Italian of middle size.—In dress the German is shabby; the Englishman superb; the Frenchman changing, the Italian a tatterdemalion.—In keeping a secret, the German forgets what he has been told; the Englishman conceals what he should divulge, and divulges what he should conceal; the Frenchman blabs every-

thing but the Italian does not utter a word.—In manmanners the German is clownish, the Englishman barbarous; the Frenchman easy, the Italian polite.—In vanity the German boasts a little; the Englishman despises all; the Frenchman praises everything and the Italian values little what is of little value.—In offending and doing good, the German does neither good nor bad; the English does both without reason, the Italian is prompt in beneficence but vindictive.—In giving advice the German is slow, the Englishman resolute; the Frenchman precipitate and the Italian nice.—In speaking, the German speaks little and badly, but writes well; the Frenchman speaks and writes well; the Englishman speaks badly but writes well also; the Italian speaks well, and writes much and well;—In address the German looks like a blockhead; the Englishman resembles neither a fool or a wise man; the Frenchman is airy; the Italian is prudent, but looks like a fool.—In laws, the German laws are indifferent but rigidly observed; the Englishman has bad laws, but observes them well; the Frenchman has good laws, but observes them badly.—Servants are companions in Germany, slaves in England, masters in France, and respectful in Italy.—Diseases, the Germans are particularly infected with fleas, the English with whitlows, the French with small-pox and the Italians with the plague.—The women are housewives in Germany; queens in England; ladies in France; but captives in Italy.—In courage, the German resembles a bear, the Englishman a lion; the Frenchman an eagle; the Italian a fox.—In sciences, the German is a pedant; the Englishman a philosopher; the Frenchman has a smattering of everything, the Italian is a professor.—Magnificence, in Germany the princes; in England the ships; in France the court and in Italy the churches.—Husbands (make conclusion); in Germany they are masters; in England servants; in France companions and in Italy schoolboys."

It has occurred to me that these odd opinions, formed a century ago, are of passing interest in view of the present European war.—Yours very truly,

London, K.
March 4th, 1916.

Dear Sir,—I understand that you are making lists of old Guy's men and their doings in the war. I am, therefore, sending you my record. In October, 1914, I went to France as surgeon to the Croix Rouge Français; and was invalided home at the end of December, and had to take a sea-voyage for my health. On July 3rd I was appointed Resident Medical Officer to the above hospital and have been here ever since that date. On February 10th, 1916, I had the honour of conducting His Majesty King George V. round this hospital.—Yours faithfully,

EDWARD M. MAHON,
M.R.C.S. Eng., L.R.C.P. Lond.

Endsleigh Palace Hospital for Officers,
February 18th, 1916.

EXAMINING BOARD IN ENGLAND

BY THE

ROYAL COLLEGE OF PHYSICIANS OF LONDON

AND THE

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

First Examination.

This Examination will commence on Tuesday, March 28th, 1916.

Students are admitted to the Examination on producing evidence of having received instruction in the subjects thereof, in accordance with the conditions of the Regulations.

Candidates intending to present themselves for a part or parts of the Examination must give fourteen days' notice in writing to the Secretary, at the Examination Hall, 8-11, Queen Square, London, W.C., from whom all particulars relating thereto, including the Regulations and Synopses of the subjects, may be obtained.

Second Examination.

This Examination will commence on Thursday, March 30th, 1916.

Students who have completed the required professional study, and who desire to present themselves for examination, must forward the necessary schedules through the post to the Examination Hall, 8–11, Queen Square, London, W.C., fourteen days before that date.

Third or Final Examination.

The Examination will commence on Tuesday, April 4th, 1916.

Students who have completed the required professional study and have fulfilled the other necessary conditions and desire to present themselves for examination in either or all of the subjects must forward the necessary schedules through the post to the Examination Hall, 8–11, Queen Square, London, W.C., fourteen days before the Examination commences.

1st February, 1916. FREDERIC G. HALLETT,
Secretary.

Birth.

PARRY-PRICE.—On February 21st, at Castle Hill, Reading, the wife (*née* Elsie Bevan) of H. Parry-Price, Surgeon Royal Navy, of a son.

Marriage.

INGRAM—MACTAGGART.—On the 19th February, at St. Mary Abbotts, Kensington, W., by the Rev. C. L. Feltoe, D.D. (uncle of the bridegroom), Percy Cecil Pasher Ingram, M.B. Lond., Captain R.A.M.C., T.F., eldest son of Colonel S. D. Ingram, V.D., to Dorothy Fanny Mactaggart, daughter of Edmonds Massie of the Stock Exchange, and widow of F. D. Mactaggart of Singapore.

Death.

TA'BOIS.—On the 4th February, at Winfield, Woodford Green, Essex, Isabel Franceys, the dearly loved wife of Frederick William Ta'Bois, L.D.S. Eng., aged 44. "Till the shadows flee away."

F. A. K.

GUY'S HOSPITAL GAZETTE.

VOL. XXX., No. 723.] MARCH 25, 1916. [SIXPENCE.

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Passim.

WITH so many of our contemporaries joyously expecting the advent of spring, the coming sunshine, the flowers—and, perhaps, peace, we feel it a pity to pass on without recording some of our own impressions of this time. So far our portion has been mainly of Boro' mud, rain and cold, with bronchitis and catarrhs innumerable, both to suffer and to treat. Our old friend, the park rook, the best we can do in the way of a cuckoo, has been heard and seen on odd occasions, and we wish him more success and safety than he seems generally to enjoy.

In delighted anticipation, eyes tired of gloom and dimmed electric lights watch the earliest preparations of our treasured grass plots—not to mention the now well established cricket pitch which relieved and revived many a weary mind and arm during the last summer. We are told the turf is to be super-excellent this year, and the very best quality reinforced glass has been inserted into all windows within reasonable range.

YET during these coming wonders of contentment, even as now, it is quite possible that a house officer *will* return from a music hall, that a dresser *will* find cocoa by the surgery fire, or someone drink even deeper in the cup of luxury, and still we would not criticise, for in very justice it must be said that the days when Guy's held men centred upon ought else but their duty are fading slowly into the past. We say this in remonstrance against certain views expressed, perhaps only in jest, by one or two Guy's men and old companions now far afield. We publish one such letter in this issue, and would point out in return that under present reduced conditions Guy's is an excellent spot to teach one to smile at life and a place where a man might even make himself useful.

IN later pages we have mentioned the retirement of our janitor, Mr. John Morley, after 35 years' service in the Medical School. It has been decided to call for subscriptions from Guy's men towards a presentation to be made in recognition and appreciation of his long and devoted services. Contributions should be sent to Mr. S. H. Croucher, at the Medical School offices, Guy's Hospital.

WE hear of the resignation from ill-health of Mr. R. A. Holmes from his appointment as H.P. to Dr. Fawcett. All will be sorry to lose him and his companionship. We sympathise with the house officers in the occasional overburdening of their shoulders with work and responsibility which must of necessity arise when through cause of illness or duty their ranks are temporarily depleted without a hope of reinforcement

WITH regard to the Biennial Festival, Mr. F. J. Steward, as Hon. Sec., has asked us to invite the opinions of old Guy's men as to the advisa-

bility of holding the dinner this year. A letter from Mr. Steward appears later in this issue.

On Saturday last Guy's XV. played its closing game of the season, and we would most heartily congratulate Messrs. C. L. Curle, Kidman, and others, on the way they have managed these games, which have been most enjoyable and more than appreciated, both by our opponents and ourselves. The summary of wins and losses is not to hand, but considering the difficulty latterly in raising a representative team the results have been quite gratifying.

Received from the Central Medical War Committee Offices, 429, Strand, W.C., we have the following notice with a request for publication :—

RECRUITMENT OF DOCTORS IN ENGLAND AND WALES.

We are officially informed by the War Office that, in accordance with their previous announcements, doctors who have undertaken to accept a Commission in the Royal Army Medical Corps (if offered one) will not be taken for general service ; and therefore that any doctor n England and Wales who (whether attested under the Derby scheme or not) has enrolled under the scheme of the Central Medical War Committee, or has offered his services in the Royal Army Medical Corps direct to the War Office should, if he receives a notice paper from a recruiting officer calling him up (whether by reason of attestation or under the provisions of the Military Service Act), return it to the recruiting officer, together with his certificate of enrolment, or the War Office acknowledgement of provisional acceptance, as the case may be ; and the notice will then be cancelled and the practitioner remain in the Reserve until selected for a commission in the Royal Army Medical Corps.

Doctors will not be called up, whether by reason of attestation or under ihe Military Service Act, until after March 31st, 1916.

Doctors in England and Wales who have not undertaken to accept a commission (if offered one) in the Royal Army Medical Corps will, when called up (whether by reason of attestation or under the Military Service Act), have the same rights of appeal for exemption as men who are not doctors ; but all cases coming before the Central Tribunal will be decided by that Tribunal after receiving advice from the representative committee of the medical profession specially recognized for the purpose.

Analogous arrangements will obtain in respect of doctors in Scotland.

Guy's Hospital Biennial Festival.

Dear Sir,

At a recent meeting of the Staff, informal mention was made of the Biennial Dinner, which. under ordinary circumstances, would take place in the summer of this year. Those present were of the opinion that it is not desirable to have the dinner, but I was asked to invite the opinions of old Guy's men regarding the matter through the medium of the Gazette. I should, therefore, be glad to hear from anyone who considers that the Dinner should take place as usual, and should there be any considerable number of opinions expressed to this effect, I will then summon the usual formal meeting to consider the question.—Yours, etc.,

F. J. STEWARD,
98, Portland Place, W. *Hon. Sec.*

A Guy in Guy's.

(BY ONE OF OUR RECRUITS.)

They undressed him and compressed him,
And with other things distressed him;
And they catalogued him "Left Inguinal Hernia," eh, what?
Then all modes of fashion shocking,
They produced a kind of stocking
That would easily accommodate more legs than he had got.

Then, by way of a diversion,
They provided an excursion
To a theatre where the actors seemed so silent and aloof,
Where they opened "Little Mary"
In a style quite cute, though wary,
And solutioned up her inner tube and made it puncture proof.

Then they brought him back to "Blighty,"
Neatly tucked up in his nighty,
And he slumbered, with exception of occasions when he'd yelp;
And in language of great power
He'd orate for quite an hour,
So that night nurse simply had to stop her ears and call for help.

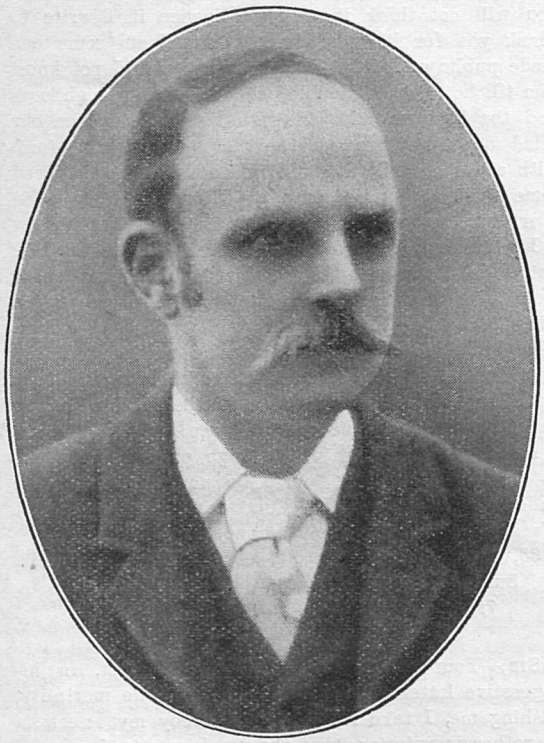
And after many hitches,
When "eleven" saw his stitches,
He was so completely shaken that he murmured, "well I'm blowed,
"Like the soldiers in their missals,
"I'd rather sleep on thistles,
"If they're the sort of stitches that Sister Susie sewed."

Gazette Special Pathologist.

V. J. H.—Westgate-on-Sea, *re* Mrs. H.—Specific gravity, 1,024 : reaction, acid; albumen, a trace; blood, absent ; sugar, absent. The centrifugalised deposit cleared of a large amount of urates is considerable in amount and consists chiefly of uric acid. Microscopically a moist preparation contains in addition, mucus a small number of leucocytes, and a small number of epithelial cells from the lower urinary tract. Tube casts, pus, cells suggestive of new growth or other abnormalities are not detected. PATHOLOGIST.

Retirement of the Medical School Janitor.

At the retirement of our Janitor, Mr. John Morley, after thirty-five years of service, the Medical School loses a figure known to many Guy's men, past and present. Always a zealous guardian of the School's inmost secrets, always an unwavering recorder of all men's activities, both good and bad, always a most obliging assistant, he will be well remembered by all who have passed before his watchful eye.



John Morley.

He first came to Guy's on Saturday, October 2nd, 1880, when the Medical School Office was adjoining the Dispensary, and consisted of one room, not large, and furnished more as a private apartment than a business office. Later a small part was partitioned off as an extra room, and later still another was added as the Dean's room. In those days the Dean was Dr. Frederick Taylor, and the Clerk Mr. Wells, who later migrated to the Treasurer's Office after eight or nine years' service in the Medical School. After Dr. Taylor came Dr., now Sir Cooper, Perry, followed by Dr. Shaw, who held office for several years.

The first lecture Mr. Morley attended to "take names" chanced to be upon Chemistry, by Dr. Debus, in the then Chemical Theatre at the back of the old Library, near the Superintendent's Office. He knew nobody, and had to ask all names as they entered. Some few—or was it many?—gave the information required and passing into the theatre, passed out on the other side. No doubt they thought they were duly "marked up," and so they were!

Speaking of those early days, Mr. Morley describes how the old Medical School Buildings stood in place of the now revered grass plot adorned in summer by many deck chairs and their fair occupants. Since demolished, these buildings consisted of a theatre, three class rooms, the museum, a curator's room, and a prosector's room, where specimens were prepared for illustrations at the anatomy lectures. The theatre held about one hundred and fifty, and was nearly always full at nine o'clock lecture; indeed, very frequently some dozen or more stood at the back or brought stools from the class rooms adjoining! Among the lecturers were Mr., now Sir Henry, Howse, Mr. Davies-Colley, Dr. Pavy, Dr., later Sir Samuel, Wilks, Mr. Durham, Mr. Bryant, and many more now famous names.

He tells of the origin of the Students' Club, in an unused ward in the medical block, arranged as a dining-room and a reading-room. In this ward, too, was held the annual Conversazione, at the beginning of the winter session, when, at a crowded and enjoyable function, prizes were distributed and the speeches made.

Later on the Dental School began its existence in the same place and with two students—Messrs. Hopson (the present Dental Surgeon), and Haynes.

More recent changes are perhaps too well known to be mentioned here, but in bidding good-bye to one who has seen so much of the active development of our present surroundings, and known so many of those who helped to create them, one feels in accord with the whole of Guy's in expressing appreciation of the long and devoted services of one of the Medical School's best known units. F. A. K.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the Gazette *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR MR. EDITOR,—In the last GAZETTE I was fortunate enough to see I read an impassioned, not to say an eloquent, letter from Mr. Layton on the subject of enlistment. I will not be drawn into an argument, even on paper, with a superior officer, least of all with the writer of that letter, yet if doctors are so urgently needed, I sometimes wonder why, along with eight other medical men, I should have been given a free passage (with allowances bien entendu) half across Europe, visiting many places, stopping at not a few, being pushed here and there seeking work, until eventually we land on an island only to find our quest in vain. Not that we do not work. Figure to yourself, dear Mr. Editor, that I have been on two Courts Martial as an advocate; and have tasted the sweets of success; that I have in turn played my part as King's messenger, interpreter, surveyor, foreman dock labourer; and rendered yeoman service in many other capacities; added to which none is more expert in the art of pitching camp and striking it again. Neither must I omit to say that my masseters are keeping up to the strain in an undreamt of manner.

It would take me, dear Mr. Editor, many days to recount, even briefly, our manifold activities. Yesterday, for instance, I found a Serbian doctor reading Osler, and would you believe it, I read him a paragraph on cholera, and then stayed and had coffee with him. On my arrival back at camp I took out a tooth. I am thinking seriously of applying for specialist's allowance. It is one thing to work, but it is another thing to work oneself to death. Oh yes, I forgot to tell you that we form, or rather are, a hospital. Of course we are not really a hospital, but a field ambulance constituted for surgical cases only; but now, and quite naturally too, we are a hospital for medical cases only. We have been expecting patients for nearly a fortnight now, and really the excitement from day to day is quite unsettling. I cannot quite understand how it is that we have not resumed our travels. Certainly I do not think it is quite fair to keep us in such imminent peril of a nervous breakdown.

In our spare time we manage to bathe now and then, ride into town on a lorry, or take a trip in a motor boat; pick violets and roses, fresias, etc., drive a bargain with a Greek countryman! Write an occasional letter, and if we are not too busy, have a quiet game of bridge towards the small hours of the night. Sometimes I recollect that there are men at Guy's also awake at that hour burning the midnight oil. Some house officer, perchance, returning from the theatre, some dresser drinking cocoa in the Front Surgery: I wonder, sir, do these gentlemen give me, and many others like me, a passing thought. Do they, think you, say to themselves, Ah, that fellow N——, by Jove, he's a good man, working hard in the trenches while I'm drinking in front of the fire. Do they reflect for one moment, sir, that but for their leisure I might also taste the sweets of a little relaxation.

Major Layton has said, join the army. I re-echo the cry to the fullest extent of my lung capacity. You may forget your medicine, but you will learn to smile at life. You may even be useful.—Yours, etc.,

5th March, 1916. GUY NEELY.

MY DEAR SIR,—Your appreciation of dear old MacIlwaine was reprinted in local paper, and I hope you will not think it an impertinence if I write to thank you for it and say how glad I am some one made public a little of what he was. I did not know him till he came to Redhill, where we were neighbours and the best of pals. Though both of us over our salad days, we were devoted to sport in any form with a ball—tennis, Badminton, and we even achieved some skill at "ping pong." What a cheery good sportsman he was!

I have, happily, had very few sad times in my life, but I think the most miserable hours I ever spent were after meeting Mac on my way from the station when he told me he knew what was wrong with him. How bravely he took it! Then he went out of my life; for I felt he would rather go through it alone; but I shall never forget him and the good times we had together. May he rest in peace!

I heard from others of the high opinion every one at Guy's had of him, and I do not believe he had an enemy in the world. Forgive my troubling you; it's a satisfaction to me anyhow.—Yours truly,

38, Craves Park, SPENCER W. GRANT.
Surbiton,
7th March, 1916.

SIR,—Your correspondent, A. E. Boycott, in his suggestive letter asks for figures of infantile mortality, wishing me, I take it, to prove thereby my assertion, or rather imputation, that the employment of married women is a potent factor in producing the high infantile death rate in certain districts. Much as I regret it, time has not permitted me to examine as fully as I could have wished the distribution of the high mortality districts in the Report of the Registrar General for the year ending October, 1915. But the coincidence of a rising infantile death rate with the employment of married women on an altogether unprecedented scale is, at least, a cogent argument in favour of my hypothesis. Turning, however, to conditions obtaining in pre-war days, we find that in the towns with a high percentage of employed married women, the infantile mortality is also high, though, as Mr. Boycott points out, the converse that a high infantile mortality is always coincident with the exten-

sive employment of married women does not hold good. Let me reproduce a table from Dr. Johnston's interesting booklet, "The Wastage of Child Life" (Fabian Socialist Series, No. 7), illustrating this point, with reference to a number of Lancashire industrial towns.

	Average Infantile Mortality, 1896–1905	Percentage of Women occupied between ages of 15—35	
		Total.	Married or Widowed.
Burnley ...	208	90·9	59·7
Preston ...	208	89·4	50·5
Stockport ...	204	68·1	—
Manchester ...	187	63·3	—
Blackburn ...	183	91·8	63·9
Oldham ...	170	87·3	33·4
Bolton	166	87·4	24·7
Bury	164	88·9	44·8

The high death rate in Birmingham has been already referred to. Roughly, one may say that industrialism, whether or no accompanied by the utilization of married female albour, is a determinant of the infantile death rate. Thus, in Lancashire the town of Southport, which is a health resort for the upper classes, though not removed fifty miles from the blackest districts, has a mortality of but 99. Rural districts have in all cases a far lower rate than urban areas. Indeed, it is probable that the migration to large centres of population has done much to counterbalance the good effects of improved hygiene and medical attendance. Thus, in 1851 the dwellers in rural and urban districts were evenly divided; at the present time they are 22 and 78 per cent. respectively, and while the general death rate has declined steadily during that period, the infantile mortality has, if anything, tended to rise until the last five or six years. The problem is one which is influenced by many factors, but certainly the gravest indictment must be laid against industrialism, not only in demanding the labour of married women, after the period of actual confinement, but in forcing them to work until within a few weeks of delivery and to resume again after the shortest possible period. Undoubtedly, however, parental ignorance and neglect, as your correspondent points out, play their part. Nevertheless, it is significant that in Norway and Sweden, where the factory system as we understand it is virtually non-existent, despite the severer climatic conditions, the infantile death rates should be respectively 67 and 87 per thousand; and in Ireland, not, surely, remarkable for modern hygiene, in 1912 the figure was 86.

In conclusion, let me express a hope that practitioners in working-class districts throughout the country will send some of their most valuable first-hand observations to the Gazette to bear out or refute my conclusions. G. H. F. G.

Common-sense Eugenics.

II.

In my previous article I discussed the disgenic effect of war upon the manhood of the nations that wage it, disposing, I hope, of the pernicious argument that warfare is one of the instruments of natural selection for the elimination of the unfit. It is now necessary to discuss one or two other aspects of eugenics—preventive and negative eugenics, *i.e.*, the discouragement of the parenthood of the unworthy and the preservation of the race from certain inherited taints, which tend to diminish the effectiveness of the stock. One aspect, at least, of preventive eugenics is adequately considered in another column in the Report on Venereal Diseases, where the importance of gonorrhœa as a cause of sterility, ophthalmia, neonatorum, etc., is emphasized. But many other poisons affect the race surely, though perhaps less obviously, though outside medical circles their recognition will be a tardy one. For most people, still, eugenics is the encouragement on broad grounds of healthy parenthood, and the idea of the duty of protecting future parents from the twin deities Bacchus and Puapus a new one. Apart from the increased dangers for alcoholics of contracting venereal disease, much evidence goes to show that alcohol itself has a profound and comparatively rapid deteriorating effect upon the germ plasm. The number of these racial poisons is limited, and it is, therefore, all the more important to protect parenthood from them. Some are directly occupational, such as plumbism, which affects the fœtus through the placental circulation, others, such as rheumatism and tubercle are, or may be, inherited within the more general meaning of the term, both of which, however, are largely diseases of environment; given other conditions they would not have been contracted by the parent. Others, again, such as malaria, are endemic, and their elimination awaits the introduction of improved hygiene. In the case of alcoholism, as Dr. Saleeby points out, the inter-relation between it and syphilis and degeneracy generally is so complex that it is nearly impossible, failing a Wassermann reaction in every case, to determine whether it is the cause or the result of the other defective symptoms. For this reason the work of many observers becomes invalid, notably the observations of Dr. Mary D. Sturge and Sir Victor Horsley whose numerous data on the effects of parental alcoholism ignore this common fallacy. The work, however, of Bertholet, in Lausanne, is pretty conclusive proof that alcohol, apart from its complications, has a very rapid and profound effect upon

offspring. Following upon this observer's conclusions one would be tempted to suggest that the germ plasm, contrary to Weissman, is the most sensitive of all the tissues.

In negative eugenics, the discouragement of unworthy parenthood, we need, above all, clear definitions. The eugenist in saying to an individual, "Because you are suffering from such a defect, you should not marry," means, in effect, "you should not beget children," a thing which, legal euphuisms apart, is vastly different. Moreover, with our present knowledge—it being still debatable whether, for example, there is such a thing as an inherited tendency to tuberculosis—the need for cautious conclusions cannot be overemphasized. Here some argue, for instance, that infection is universal, and natural immunity the only factor which determines the incidence and issue of the disease, whilst the opposite and, in most respects more rational view that it is due, in the main, to bad hygiene and general physique, would place no bar upon the mating of one or even both tuberculous parents, excluding, therefore, a great range of diseases, *e.g.*, certain forms of paralysis, inherited (supposedly) tendencies to gouty and rheumatic ailments, rickets (as to which no genetic assertions can be made), what really remains for the field of negative eugenics? Leaving aside various medical curiosities as hæmophilia, night blindness and other rare anomalies, there is yet a large class of cases in which positive inheritance is a proved fact. Such, for example, are certain types of insanity, deafmutism, epilepsy, inebriety. Thus, especially, mental deficiency seems to behave as a Mendelian recessive, appearing, that is, according to the Mendelian laws of inheritance and in all probability due to the absence of some specific genetic factor. In the case of deafmutism, Dr. Kerr Love, of Glasgow, has demonstrated, when other causes such as congenital syphilis and injury in early life have been set aside, a form of genetic deafness which descends definitely from generation to generation. Similar work remains to be done in the case of neurasthenia, epilepsy, insanity, and so forth. But with our present meagre equipment of knowledge it would be presumption to dictate to any person suffering from some form of these maladies, for it is only in the rarest instances that a pedigree can be traced, giving uncontrovertible proof of their inheritability. The great need of eugenics at the present time is for records of all sorts, such as have been for the last ten years collected with such exemplary zeal by the workers at the American Eugenics Record Office, for without them, supported, if possible, by such clinical tests as the Wassermann reaction, one cannot hope to ascertain the true relation of disease and inheritance. And to some of the more enthusiastic members of the Eugenical Society perhaps the advice of a wise old statesman will not be amiss—"*Surtout point de zèle.*"

G. H. F. G.

Obituary.

WILLIAM HOWARD NICHOLLS, M.R.C.S. Eng., Captain, R.A.M.C.

Captain W. H. Nicholls, who was killed by an accidental gunshot wound at Jhansi, Central Provinces, India, on Feburary 22nd, at the age of 24 years, was the only son of Mr. H. H. J. Nicholls, M.R.C.S., of Worthing, who was for many years in practice at Eastbourne. He was educated at Bradfield College and Guy's Hospital. Though near his qualifying degree at the London University, on the outbreak of war he passed the conjoint examination and immediately entered the R.A.M.C., in which he was gazetted captain in 1915. He was a boxer and all-round athlete, and shared in the men's games, and was very popular with them. Whilst in medical charge of the Norwich Flying Corps he utilised his knowledge of mechanics and natural interest in machinery to learn to fly himself, and he was granted a pilot's certificate in January, 1916, an unusual distinction in the R.A.M.C. Soon after this he was ordered abroad and met his death not long after reaching India. In private life he was a keen sportsman and a small yacht owner, and there will be sorrow in many a Worthing fisherman's home for the loss of a liberal friend.

A New Method of Rapid X-ray Localisation.

THE call for accurate localisations of foreign bodies by means of the X-rays has become acute during the last few months. It is a regrettable fact that in a few military hospitals the most antiquated and unsatisfactory methods are still in vogue. I think, therefore, the time is opportune for bringing forward this entirely novel method of ascertaining the depth of embedded foreign bodies.

Mechanicians are now at work evolving a simple and businesslike method of applying this system, and for this reason I merely state the principle. The tube is moved a short distance, and the length of the excursion of the shadow of the foreign body noted. The screen is now raised until this excursion has doubled itself. The distance the screen has been raised is the depth of the foreign body. The extraordinary ease with which this can be accomplished, and the fact that no measurements are required except those given above, make this system, to my mind, the simplest and best I have ever come across.

I hope, in a very short time, to be able to describe a piece of apparatus that will enable the depth of any foreign body to be ascertained in a few seconds, and I think that such a piece of apparatus will be appreciated by the Guy's men, at least, who are making use of the X-rays for military purposes.

EDWARD W. H. SHENTON.

126, Harley Street, W.

The Treatment of "Concussion Blindness."

By Captain A. W. ORMOND, R.A.M.C. (T).

One of the principal ocular features of the present War is the number of cases of functional blindness due to the violent explosions caused by high explosive shells, bombs, hand grenades, &c. These cases may or may not have sustained definite organic injuries, but the clinical symptoms characterizing their functional nature are very clearly marked.

Usually the patient has been rendered unconscious by an explosion in his close vicinity, and on regaining consciousness he finds that he is unable to see. When examined he presents the following symptoms: The eyes are kept closed, the lids may be frequently "fluttered," or, as one man stated, "he could not keep his eyes from twinkling." On attempting to open the lids the patient resists forcibly by means of his orbicularis; when this is overcome to a sufficient extent to see the globes, they are found to be rolled forcibly upwards, and the pupils are always kept covered by the lids; he has great difficulty in looking downwards, and complains of pain and photophobia, and shows marked fatigue as a result of the examination. In some cases I have noticed an acceleration of the pulse-rate and also perspiration. The photophobia is not, however, really influenced by light, as the condition does not diminish in very subdued illumination; these patients never move about as blind men would, they invariably avoid hurting themselves; but all the same they never relax, even if watched for weeks at a a time, the groping action of people with extremely defective sight, and judged by every test they maintain this condition indefinitely, and are undoubtedly psychically blind; the pupils react normally, and the fundus shows no definite change. There is no difficulty in differentiating them from malingerers, as they pass through long periods of real mental distress and serious discomfort. These cases vary enormously in severity; some recover rapidly, others seem to go on indefinitely if not treated or treated unsuccessfully. Any lack of recognition of the condition in the early stages enormously prejudices the prognosis. One case having been told that he was blind remained so for several months, whereas, probably, if it had been recognized earlier that he was not blind and would recover, he would have done so much more rapidly.

Early in the War I treated these cases in several ways, all with disappointing results; some of the slighter cases certainly did recover, but they recovered in spite of treatment and not on account of it. The main principles on which I worked were rest, tonics, deprivation or punishments, such as abstention from tobacco, &c., confinement to bed or in isolation rooms, persuasion, encouragement, counter-irritation, talking, &c., but all these means were comparatively ineffective until suggestion and hypnosis were tried. In August, 1915, I thought it would be advisable to try suggestion, although I had a strong personal prejudice against its use; but when later on these cases still remained on my hands, I consulted with Major Hertz and we decided to start the hypnotic treatment. The method employed was to have the men singly in a darkened room, quiet, and resting in the most comfortable armchair the ward would provide They were instructed as to what was to be attempted, and no demur was ever made by any of them, but on the contrary, after the first experience, they were always eager to continue the treatment. The patient had his eyes closed of course, so that the assistance of light and fixation could not be obtained, but he was told to think of something pleasant and agreeable, not to take the slightest notice of the operator, and to relax his mind by attempting to stop all incoming thoughts and to make his mind, as far as possible, a blank; we then used the usual methods of inducing hypnosis. In some cases—for example Private B.—the hypnotic condition was obtained, but not in all, and I do not think it at all necessary to obtain complete unconsciousness; the main thing to be arrived at is to obtain a relaxation of the patient's mind and his muscles, and to overcome his unconscious resistance.

The treatment is carried on thus for a few minutes, and having obtained the sleepiness or light hypnosis necessary, the patient is subjected to a forcible suggestion from the operator, who reiterates the patient's ability to see and to open his eyes, and asserts very vehemently that he is not blind as he imagines, but that his eyes are perfectly sound and that he *can* see.

The results have varied considerably as to rapidity of recovery, but all have shown marked improvement, the most drastic being that of Private B. (Case 1), the most resistant being the deaf and blind man, Corporal W. (Case 3). Cases of this nature have been

constantly arriving from France and Gallipoli, but I here insert the notes sent to me by Major Hertz immediately previous to his departure for Alexandria, as they were the earliest ones with which we dealt and are quite typical, and in all of them, except in the last case, Major Hertz collaborated with me in their treatment; they, however, only represent a small proportion of the total number of cases.

NOTES OF CASES BY MAJOR A. F. HERTZ, R.A.M.C.

Private B., aged 22, was looking over a parapet on July 18th, 1915, when a shell struck the sandbags in front of him. He remembers the sand being thrown up into his eyes, and falling back so that he knocked his head. He remained unconscious for twenty-four hours. When he regained consciousness he found that he was completely blind, except that he could just distinguish light from darkness with his left eye. His eyes felt very sore, and his eyelids were constantly moving up and down. He was partially deaf and had a severe headache. His hearing soon returned and the headache rapidly improved, but the condition of his eyes had not altered when I first saw him with Captain A. W. Ormond on September 17th. He was quite blind, and there was a constant flicker of his eyelids, which were kept almost closed. On forcibly opening his eyes they were found to be turned so far upwards that it was difficult to see even the iris. A few fragments of sand were still embedded in the conjunctiva, but not in the cornea; there was no inflammation present. The patient was easily hypnotized, and whilst asleep he was told that he would be able to see when he woke up. The moment he woke the suggestion was repeated very forcibly, and his eyes were held open. He cried out that he could see, tears ran down his cheeks, and he fell on his knees in gratitude, as he thought that he was permanently blind and believed that his sight had been restored by a miracle. When seen again on September 20th, the external appearance of his eyes was normal, and he said that he was able to see as well as he had ever done. Captain Ormond, however, found that there was some opacity of the vitreous of the left eye, the result of a hæmorrhage from a retinal vessel, which had ploughed its way forward; this was doubtless a result of injury at the time of the explosion. There has been no return of symptoms, and the patient was well in every way when I last saw him on September 30th. His vision was $\frac{6}{6}$ in the right eye and $\frac{6}{36}$ in his left.

Lance-Corporal H. had an attack of blindness, resulting from conjunctivitis, caused by a sandstorm when in Egypt early in 1915. He recovered from this after ten weeks, and six weeks later went to ths Dardanelles. On July 12th a shell struck a sandbag immediately in front of him and the sand flew into his eyes. He did not lose consciousness, but his sight gradually became more and more deficient until, at the end of ten days, he was only just able to distinguish light from darkness, Very slight improvement occurred spontaneously, but his condition, when seen on September 17th, was identical with that of Private B., a few pieces of grit being still embedded in his conjunctivæ, although there was no inflammation. He was easily hypnotized, but there was very little improvement at the moment. Considerable improvement, however, occurred during the next three days. He was hypnotized on three more occasions; he could see perfectly well on September 30th, but still had some photophobia and wore dark glasses, as he could not avoid constantly blinking when they were removed. He was therefore hypnotized yet again, and it was suggested to him that the photophobia and blinking would now cease. The result was completely successful, as all symptoms had disappeared by October 4th, although no attempt had been made to remove the grit from the conjunctivæ.

Private C., aged 20, was rendered unconscious for a few minutes as a result of the explosion of a shell near him on August 21st in the Dardanelles. Some of the powder was blown into his eyes, which were very sore when he regained consciousness, although he was still able to see quite well. During the next twenty-four hours his vision became more and more impaired. The powder was removed from his eyes when he was taken on board the hospital ship, and his eyes were bandaged. After a few days he thought he would be able to see quite well if the bandages were removed, but the medical officer in charge told him that it would be dangerous to do so. During the voyage home he was not allowed to remove the bandages, and he became more and more convinced that this must be because the medical officer thought he was blind. The bandages had not been removed when he was admitted into the hospital on September 25th. When they were removed he was found to be in exactly the same condition as Private B. and Lance-Corporal H. He could distinguish light from darkness, but was unable to see anything, and he kept his eyes turned up and his eyelids

closed and constantly contracting. On September 27th he was hypnotized by Captain Ormond, after which he found he could see quite well, but the light still worried him and the blinking continued, though to a diminished extent. He completely recovered subsequently and returned to his depot.

Lance-Corporal S., aged 29, was knocked over by a high explosive shell in the Dardanelles and remained unconscious for a considerable time. On coming round he found he could only distinguish light from darkness; there was no smarting of the eyes, but he constantly blinked. He had a slight headache, but was otherwise well. He began to improve about September 10th, so that he could recognize shadows passing in front of his eyes, but no further improvement occurred until he was hypnotized on September 18th. There was very slight improvement as the result of suggestion at the time, but when seen again on September 20th he said that he was beginning to recognize objects, and the blinking was less marked than before, but he still kept his eyeballs turned upwards and his eyes almost closed. He was hypnotized again on September 20th and 25th, and when seen on September 30th his sight was quite normal and the blinking had completely ceased. Subsequent retinoscopic examination revealed the presence of a considerable degree of myopic astigmatism in the right eye and mixed astigmatism in the left.

Corporal W. was signalling from a gun limber on April 28th, when he was blown up and remained unconscious for six days. There was no external wound, but on regaining consciousness he found that he was blind, except that he could just distinguish light from darkness; he was also completely deaf and was unable to speak. He regained his speech in June, after a fortnight's treatment by hypnotism at Plymouth, but his sight and hearing remained unaltered. When I saw him on September 17th he could only be made to hear by shouting down an ear-trumpet; he kept his eyelids almost closed and constantly twitching, with his eyeballs turned upwards. He was extremely depressed, as he had been told by an aurist that he would never regain his hearing, as it was said that nerve deafness of such long duration could not improve, although the drums were intact. He concluded that the blindness would also be permanent. It was not easy to hypnotize him, as he was unable to see and all suggestions had to be shouted down his trumpet, but Captain Ormond succeeded in doing this at the first attempt. When seen on September 20th, he said that his sight was distinctly better and he was able with difficulty to open his eyes. He was much more cheerful, particularly when we told him that his hearing would also return, as his auditory nerves were no more organically diseased than his optic nerves. On September 30th there was some further improvement, as he could see everything in the outer part of his left field of vision fairly well. He was having a good deal of domestic worry, which no doubt prevented a more rapid improvement.

Private A. was unconscious for an hour after being blown up by a shell on August 7th. He was unable even to distinguish light from darkness when he recovered consciousness, but he very gradually improved. He was admitted into the hospital on August 22nd, after which improvement was much more rapid, and by the middle of September he had quite recovered without any special treatment.

Lieutenant C., aged 20, had never used his left eye owing to an extreme degree of hypermetropia and amblyopia. When the other eye was covered he could only see very indistinctly with it, but in spite of this he managed to pass the medical examination when he entered the Army. He was hit on the left side of his head by the butt of a rifle in June and was unconscious for a few minutes. When he regained consciousness he at once noticed that he could not see at all with his left eye, although he had hitherto been in the habit of neglecting the blurred image he saw with this eye. On August 10th he received a slight wound to his left thigh, but he continued on duty. The wound had not completely healed and was still somewhat painful when, on August 23rd, he was blown up by a high explosive shell. When he regained consciousness he was being carried on a stretcher. The pain from his old wound drew his attention to his left leg, and he thought that he was unable to walk. When taken on the ship he found that this was the case, although there was no new injury of the leg. He also complained of severe pain above the left eye, which he kept covered by a shade, as he found that the least light greatly increased the headache; when the shade was removed he was unable to open the eye at all. For some time he was in an extremely excited condition and he slept very badly owing to nightmares. His eye was kept covered by a shade during his journey home from the Dardanelles. On his arrival in England, Mr. C. M. Ryley found that beyond the hypermetropia his left eye was normal, although he was quite unable to see anything

with it. He was hypnotized on four different occasions. After the first he already slept better, the nightmares ceasing, and his headache was less severe. On the second occasion whilst still asleep the shade was removed from his eye, and he did not discover until half-an-hour after he woke up that it was no longer present, although up to that time he said that the least light caused extreme discomfort and spasm of the eyelid. After the third treatment he found he could see almost as well with his left eye as before he was hit on the head. Meanwhile he was still unable to walk without crutches, although the wound in the leg had completely healed, and there was no physical cause to account for this. When he was hypnotized for the fourth time it was therefore suggested to him that he would be able to walk quite well, and he subsequently recovered entirely.

These cases are typical of many others that have been treated similarly; in fact, fresh cases of this same condition are arriving every week, and the "suggestion" treatment has not failed to give marked improvement in every instance. Up to the present we have had no failures, although Corporal W. (Case 4) has proved the most resistant, but his deafness and domestic trouble, together with the very unfortunate handling of the case in the early stages, have no doubt been responsible for this. Dr. Francis Brook very kindly undertook the later stages of his treatment for me, as owing to his greater experience in this work I thought he might obtain better results than I had effected. In November the man was given an anæsthetic, and suggestion was tried during the stage of semi-consciousness, with marked success, as the following day he opened his eyes voluntarily and has kept them open ever since. His speech and his sight having now returned, we hope that his hearing will not be long delayed.

Major Hertz and I hope that by publishing these cases greater attention may be drawn to these conditions, so that even if treatment cannot be applied at once, the cases may not be prejudiced unfavourably by injudicious handling.

It is probable that the presence of sand, grit, &c.. in the conjunctival sacs of some of these patients may have been the cause of the "suggestion" of blindness, but they were not present in all cases, and recovery took place without them being removed; as a matter of fact, they were, when present, all embedded in the conjunctiva and did not produce any irritative symptoms at the time the patients were under treatment.

The Report of the Venereal Diseases Commission.*

The long-delayed report of the Royal Commission appointed in 1913 to consider the question of the prevalence, efficient treatment, and prevention of venereal disease has at last made its appearance in the form of two bulky volumes, one the findings of the Commissioners, and the second and larger the verbatim report of the evidence taken at the 86 meetings, during which 22,296 questions were asked of 85 witnesses. The general conclusions are, on the whole, conservative and the recommendations certainly do not err on the side of being drastic; the report is, however, surprisingly interesting, and, from the medical point of view, as good a resumé of the social aspects of these diseases as could be found. Much of the report is given to the consideration of the various clinical manifestations of gonorrhœa and syphilis with which the readers of this journal are, of course, familiar, though the student will find therein an excellent summary of the various late and early syphilitic manifestations, and in the various appendices the question of the treatment of chronic gleet is gone into with some thoroughness. The main interest, however, for us is in the consideration of such questions as the inclusion of compulsory courses of instruction in venereal disease, the position of the medical man with regard to the notification of disease, and the steps to be taken in order to establish free clinics and evening clinics for the working classes, where patients could be treated with least amount of publicity and inconvenience.

The report is signed by all the Commissioners, namely, Lord Sydenham (chairman), Sir D. Brynmor Jones, Sir Kenelm Digby, Sir Almeric Fitzroy, Sir Malcolm Morris, F.R.C.S. Ed., Sir John Collie, M.D., Dr. Arthur Newsholme, Canon J. W. Horsley, the Rev. Dr. J. Scott Lidgett, Dr. F. W. Mott, Dr. Mary Scharlieb, Mr. James E. Lane, F.R.C.S. Eng., Mr. Philip Snowden, M.P., Mrs. Creighton, and Mrs. Elizabeth Burgwin. The signatures of Sir Kenelm Digby and Canon Horsley are subject to certain reservations. The Commission recognise the grave disadvantages of publishing the report at such a time as the present, "when all public activities are pre-occupied in fulfilling the manifold needs of war. We are conscious," the report continues, "of the disadvantage arising, and we feel that there is some risk that our recommendations may not receive the immediate attention which their national importance demands. We desire, therefore, to place on record our strong opinion that the conditions now existing, and those which follow on the conclusion of the war imperatively re-

*Cd. 8,189, 1s. 11d.; Appendix, Minutes of Evidence, etc., Cd. 8,190, 3s. 6d.

quire that action should be taken without delay. There is no reason to believe that the percentage of infection in the naval and military forces is now greater than in normal times; but there can be no doubt that the total of infected persons has increased. The military authorities are doing their utmost to provide treatment, but the civil population requires corresponding measures, and all experience goes to show that after a war an excessive incidence of disease is certain to occur, even in districts previously free. In order to meet present and future conditions it is essential that no time should be lost. . . . We wish to lay stress, lastly, upon the needs of the future. The diminution of the best manhood of the nation, due to the losses of war, must tell heavily upon the birth-rate—already declining—and upon the numbers of efficient workers. The reasons for combating, by every possible means, diseases which in normal times operate with disastrous effects alike upon the birthrate and upon working efficiency are, therefore, more urgent than ever before. Now and in the years to come the question of public health must be a matter of paramount national importance, and no shortsighted parsimony should be permitted to stand in the way of all means that science can suggest and organisation can supply for guarding the present and future generations upon which the restoration of national prosperity much depend."

The statistics with regard to mortality, etc., from such a disease as syphilis are, of necessity, very imperfect. The methods of diagnosis have been, until the last ten or fifteen years, extremely faulty, and many of the late or para-syphilitic manifestations of the diseases were not previously recognised as such. Nevertheless, imperfect as they are, the figures of the report have quite a special interest. The mortality certified due to syphilis in the years given in the accompanying table and per million of the population were as follows :—

Year.	Total Deaths.	No. per Million.
1875 ...	2,154 ...	89
1880 ...	2,162 ...	80
1885 ...	2,196 ...	81
1890 ...	2,056 ...	71
1895 ...	2,099 ...	69
1900 ...	1,842 ...	57
1905 ...	1,811 ...	53
1910 ...	1,639 ...	46
1911 ...	1,850 ...	51

"Judging from these figures," says the report, "it might be thought that there has been a steady decrease in the mortality amounting to nearly 50 per cent. in the last 35 years, but, as pointed out by Dr. Stevenson in his memorandum, the worthlessness of the returns as an absolute statement of the number of deaths from venereal disease scarcely requires demonstration. Not only are deaths recognised as due to this cause not so entered for fear of hurting the susceptibilities of relatives, but large numbers of deaths are ascribed to other diseases now known, or beginning to be known, as due to venereal disease. For example, among other diseases, locomotor ataxy and general paralysis are not known to the public as exclusively syphilitic in origin and are therefore certified without reluctance. The same may be said of aneurism of the aorta which is mainly due to the same cause." Thus, in the table below, giving the annual deathrate per million at all ages for the diseases specified, we see a far greater annual toll from specific disease than is recorded merely as syphilis:—

Cause of Death.	1901	1902	1903	1904	1905	1906	1907	1908	1909	1910
Syphilis	53	51	55	54	53	50	48	48	48	46
G.P.I.	70	68	64	71	67	68	67	63	67	62
Loco-motor ataxy	13	15	15	15	16	16	17	17	17	16
Aneu-rism	30	32	31	32	32	32	33	30	33	31

Another interesting table is that showing the incidence of syphilis among various classes of the population. Here it will be seen that the deathrate from syphilis and three consequential diseases in the year 1911—1912 was highest among unskilled labourers and lowest among agricultural labourers, an observation which confirms the statement that venereal diseases are more common in urban than in rural districts. The classes are taken from the occupational returns of the 1911 census.

	Social Status and Occupation.	Death-rate per 1,000,000	Order.
1	Upper and Middle	302	III
2	Intermediate, between 1 & 3 ...	280	IV
3	Skilled Labour	264	V
4	Intermediate, between 3 & 5 ...	304	II
5	Unskilled Labour	429	I
6	Textile Workers...	186	VI
7	Miners	177	VII
8	Agricultural Labourers ...	108	VIII

In view of these figures there seems grounds for the belief that syphilis is most common among the highest and lowest classes of the community. The results of this distribution are shown in the high percentage of youths in Borstal Institutions suffering from congenital syphilis; of 941 inmates there were

153, or 16·26 per cent., whilst five more had acquired the disease. Of 1,775 convicts examined from all classes of prison, 299, or 17·04 per cent. showed signs of having had syphilis, whilst if they had been submitted to the serum test the numbers would doubtless have been larger. All the figures quoted are for England and Wales, the percentages for Scotland, and notably Ireland, being far lower.

The economic effect of the prevalence of venereal disease is not far to seek. Both gonorrhœa and syphilis lead to an enormous annual loss of child life. Gonorrhœa is one of the great causes of sterility of men and women. It is estimated that from 30 to 50 per cent. of sterility among women is due to this cause. Of antenatal deaths and deaths in early infancy a large proportion are due to syphilis. Registered still-births which, as the report points out, do not give full figures, are estimated to be equal to 3 per cent. of the total live births, and of these at least half are probably due to syphilis. Among children born alive, ophthalmia neonatorum accounts for 24 per cent. of the blindness in children directly due to venereal disease; interstitial keratis for 19·8 per cent. Of 1,100 children examined in the L.C.C. schools for the blind, at least 55·6 and probably 58·4 per cent. were blind through venereal disease. In the case of adults the resulting illness accounts for much economic loss and a considerable shortening of life. "The evidence we have taken," says the report, "clearly establishes the fact that the neglect of venereal diseases, apart from the risk of later manifestations, has the effect of rendering the treatment more difficult, protracted, and expensive, thus entailing a large aggregate loss of working power."

The vexed question of compulsory notification of disease is only briefly dealt with in the report. Their opinion is, however, that any such compulsion would meet with general reluctance on the part of medical men to notify such cases as came to their knowledge, and that it would lead to an even greater recourse on the part of the patients to herbalists and quacks. So, too, the question of compulsory detention in Poor Law institutions and hospitals does not meet with the unqualified approval of the commission, though here the case seems stronger. Many persons suffering from these diseases leave hospitals, etc., when their treatment is only commencing, and either do not present themselves again or only when the disease requires much more prolonged treatment. In the meantime they have been free to spread the disease far and wide. The argument that detention would be an unwarrantable interference with the liberty of the subject is met by the contention that many other diseases, fevers, etc., are already compulsorily notifiable, although they are far less dangerous to the community. Such a system of detention is in vogue in Denmark, though it seems not to be rigidly enforced. The commission most strongly recommend that venereal disease should be made a disqualification for marriage, gonorrhœa and syphilis being treated by most of the witnesses as of equal importance. The position of the medical man is, as the report points out, at present highly unsatisfactory. "The difficulty of communicating with or warning the future bride or her parents or other persons in a position to influence her action is two-fold. We are informed by many witnesses that it might be regarded as a breach of professional confidence. There is also the possibility of the medical practitioner being sued or prosecuted. There is no doubt that to assert to a third person that any person is suffering from venereal disease is a libel. . . We therefore recommend that such communication when made *bona fide* to a parent, guardian, or other person directly interested in the welfare of the woman or the man, and with the object of delaying a marriage with a person who is in an infectious state, should be deemed to be a privileged communication." That such a disease contracted before marriage should be a ground for annulling it was already recommended by the Divorce Commission; its findings are endorsed by the present report. "We believe that a statutory recognition of the principle that infectious venereal disease constitutes an incapacity for marriage would enormously strengthen the position of the medical profession in preventing or delaying dangerous marriages and would be of especial service in the case of institutional patients, with whom at present medical advice on this subject is less likely to be efficacious than in the case of private patients." Infection of either party by the other already constitutes an act of cruelty and is legal ground for a judicial separation, whilst in the case of the wife being the infected party, it constitutes, practically, ground for a divorce, since infection is *per se* an admission of adultery.

The question of the efficient education of medical students in venereal diseases is one which is carefully considered by the report. The opinion of the Commissioners is that too little instruction is received by medical students in these subjects, and in the case of the R.A.M.C. it was found necessary to give officers on joining a special course of instruction in venereal diseases. It was urged by some witnesses that the study of syphilis was necessarily included in the diseases of all the functions of the body and that in an already crowded curriculum it would be impossible to find space for an additional course of study. The Commissioners recommend that a genito-urinary clinic be established at all the large teaching hospitals, where patients can receive treatment and regular instruction be given. With regard to skin lesions, the report recommends that "in view of the frequency with which the cause of the skin rashes due to neglected syphilis remains unrecognised, we urge upon the teaching authorities the importance of arranging that every medical student shall attend a course of instruction in skin diseases." Not less important is the section

devoted to the question of educating the general public concerning the grave evils which result from neglect of venereal disease in its earlier stages. "If venereal diseases are to be stamped out, it will be necessary not only to provide the medical means of combating them, but to raise the moral standards and practice of the community as a whole. Such an improvement can only be brought about by a closer co-operation between religious bodies, the teaching and medical professions, and education authorities." The report goes on to discuss the urgent need for systematic instruction in general hygiene and sexual matters, though it does not seek to minimise the difficulties that are encountered in the case of children who leave the elementary schools at the age of 14 years. "The degree of such instruction will vary with the age and circumstances of each child, but we are of opinion that in the case of children under 14 years of age, their immaturity makes detailed instruction highly undesirable. Marked differences in temperament and also in the degree of knowledge possessed by the children must be borne in mind. In overcrowded districts very young children acquire much precocious information in the most undesirable way. In better conditions children grow up in ignorance of such matters, and this ignorance is carefully and often unwisely fostered by their parents. . . We understand that the custom is growing for head teachers (in secondary schools) to have private interviews with pupils before they leave school, or if they show special need of guidance, in order to give moral instruction and to offer warnings against probable temptations. This practice we commend, and we consider that it should become general. . . . In the case of children passing through the elementary schools, the great majority of the school population of the country, such complete instruction can be given only, if at all, in evening continuation schools, and there only if knowledge and discretion can be counted on in the teacher."

Other matters dealt with include the treatment of venereal diseases by unqualified persons, a practice which is naturally strongly discountenanced by the Commissioners. Chemists, herbalists, and quack advertisers seem to be the chief offenders, and the upper classes, according to some witnesses, resort as readily to these remedies as the poor. It seems difficult to determine whether such practice is on the increase or decrease. "Dr. Svend Lomholt stated that, in Denmark, people did not consult unqualified persons because treatment provided by the State was easily available, and because the physicians had the confidence of the population. Dr. Santoliquido informed us that, in Italy, there was very little scope for quacks on account of the free treatment rendered available to the public." The moral is obvious. The report further endorses the recommendation of the Select Committee on Patent Medicines that all advertisements of remedies for venereal diseases should be prohibited. The substitutes for salvarsan are also reported on. Of these the most satisfactory appear to be Kharsivan and the French substitute, Arsenobenzol Billon, whilst another French product, Galyl, a compound of arsenic and phosphorus, is also spoken of favourably.

The more important recommendations are: the confidential registration of causes of death; the keeping of accurate records of persons treated in hospitals and Poor Law institutions in order to secure statistical information of the prevalence of these diseases; extended facilities for diagnosis by laboratory methods; 25 per cent. of the added expense being met by Local Rates and 75 per cent. from Imperial Funds; measures to be taken to render the best modern treatment of venereal diseases readily available for all classes of the community such that persons affected will have no hesitation in availing themselves of the facilities provided; such treatment should not be restricted to persons living in a particular area, and there should be no refusal to treat a patient unwilling to go to his own doctor; evening clinics to be provided for the working classes; practitioners treating these diseases to have free access to the best modern clinics for study and instructions; cards of instruction and warning to be handed to patients; men serving in the forces not to be discharged till in a non-infectious state; the National Council for Combating Venereal Diseases should be recognised by Government as an authoritative body for the purpose of spreading knowledge and giving advice on these matters.

Such a brief and imperfect summary as I have been able to give of this most important Blue Book will, I trust, be sufficient to stimulate a few of the readers of the GUY'S HOSPITAL GAZETTE to buy it for themselves, and study in detail the tables and observations with which it is filled. At all events, let us hope its publication will do something to dispel the mists of cant and ignorance with which this subject has, in the minds not only of the general public, but, I fear, in some cases of the medical profession, been too long surrounded.

G. H. F. G.

Change of Address.

George H. Rodman, M.D., 4, Heath Mansions, Putney Heath, S.W.

Capt. S. W. Coffin, R.A.M.C., from Netley, to Overseas, c/o G.P.O., London, E.C.

Lieut.-Colonel G. T. Willan, R.A.M.C. (T.F.), c/o 82nd Field Ambulance, 27th Division, Salonica Force.

C. C. Holman, M.B., F.R.C.S., 15, Guildhall Road, Northampton.

R. B. Dawson, M.R.C.S., L.R.C.P., from Leveson House, Willenhall, Staffs., to Ednam House, Willenhall.

Capt. C. Sherris, attached 2nd Royal Irish Regiment, B.E.F.

Capt. S. W. Coffin, R.A.M.C., overseas, c/o G.P.O., London.

Millicent Sutherland Hospital, France.

A Case of Gas Gangrene caused by a perforating wound of the Chest.—The patient was admitted here with a history of having been wounded about five days previously. There was a jagged wound just above the left scapula, but no exit wound. He had had no hæmoptysis, but had been dyspnœic all along. The temperature was 103 and pulse 136. He was very dyspnœic and moderately cyanosed, but quite cheerful, and did not consider himself seriously ill. He was noticed to be slightly jaundiced. On examining the chest it was found that the whole of the left side was more resonant than the right and that there was some difference in the amount of movement of the two sides. The breath sounds were normal in type, but slightly less on the left side. The voice sounds also were slightly diminished on the left side. The heart was apparently not displaced.

A diagnosis of pneumothorax, with possibly some deep-seated pneumonia, was made. He was treated with morphia and he became less dyspnœic and cyanosed and the pulse rate diminished. He became, however, progressively more jaundiced and died the next day after having collapsed suddenly. There were no abdominal symptoms or signs. There was no surgical emphysema.

An autopsy was made next day, and it was seen then that the whole body was greatly swollen with surgical emphysema. Free gas was present in the peritoneal cavity; intestines very distended. The liver was of a mottled yellow ochre colour and was covered under the capsule with minute air-containing bullæ (1 or 2 mm. in diam.); spleen congested and frothed when cut; kidneys also contained air bullæ. The left pleural cavity, in which a piece of shrapnel lay free, contained air and about two pints of foul-smelling, blood-stained fluid. The left lung was partially collapsed. Right lung was bulky and congested. Minute air bullæ were seen under the endocardium in both ventricles. There was no excess of pericardial fluid. All the organs were bile-stained. The brain and cord were not examined. The fluid in the thorax contained bacilli of malignant œdema, bacillus aerogenes encapsulatus and streptococci.

I am indebted to the pathologist at the Lahore Hospital who performed the autopsy and the bacteriological examination. C. D.

Papers by Guy's Men.

Percival P. Cole, M.B., Ch. B., F.R.C.S., L.D.S. Eng., and Charles Henry Bubb, L.D.S.R.C.S. Eng: Deformities of the jaw resulting from operation or injury.—*British Dental Journal*, March 15th, 1916.

A. T. MacConkey, M.B., D.P.H. (in collaboration with S. S. Zilva, Ph. D.): Iodine in Tetanus.—*B. M. J.*, March 18th, 1916.

Guy's Men in Malta.

It has been suggested that it might interest your readers to hear of the coming together of Guy's men in the little island of hospitals on January 28th, 1916. We mustered 22 at a dinner at the Union Club, Valetta, at which we had the honor of entertaining an aforetime Guy's Senior Surgeon, now Colonel Charters Symonds, A.M.S., Consulting Surgeon to the Military Hospitals of Malta.

We had a simple quiet dinner in keeping with the spirit of comradeship during these troublous times. Fleet-Surgeon Marriott was elected President for the evening, with Capt. C. R. Nicholson as Vice-President.

The toast of the evening, after the patriotic, was our Alma Mater, associated with Colonel Symonds. Warm words of appreciation of the skill, tact, and kindliness of the worthy representative of our former teaching staff were received with loud applause, betokening his popularity here. Colonel Symonds replied, with a great speech full of amusing anecdotes, recalling our student days and even some cases, but more especially those delightful idiosyncrasies of the famous ones of Guy's which brought forth laughs and cheers. The dinner was a great success.

Those present were: Fleet-Surgeon H. B. Marriott, R.N., Pres., Colonel Charters J. Symonds, A.M.S., Lt.-Col. Silk, R.A.M.C., Lt.-Col. R. P. Samut, Staff-Surg. A. R. Thomas, R.N., Staff-Surg. D. Mitchell, R.N., Surg. R. A. Rankine, R.N., Surg. E. L. Elliott, R.N., Capt. J. A. Glover, R.A.M.C., Capt. C. R. Nicholson, R.A.M.C., Capt. G. Constant, R.A.M.C., Capt. L. T. Dean, R.A.M.C., Lt. N. P. Ker, R.A.M.C., Lt. E. E. Frazer, R.A.M.C., Lt. L. Horsley, R.A.M.C.,, Lt. R. B. Westlake, R.A.M.C., Lt. C. F. Fothergill, R.A.M.C., Lt. E. S. Hall, R.A.M.C., Lt. Ernest Coleman, R.A.M.C., Lt. C. P. Symonds, R.A.M.C., Lt. B. Wills Rust, R.A.M.C.

P. W .T. Camps, Capt., R.A.M.C.,
Hon. Sec. Med. Conf., Malta.

St. Elmo Military Hospital,
Malta,
February 13th, 1916.

Pass List.

Royal College of Surgeons of England.

L.D.S. (Final.)

Part I.

At the recent Examination the following candidates were approved:—G. W. Allan, A. S. Blacklaws, B. Eady, R. J. G. Halden, R. J. Hugo, C. H. Kidner, O. O. Lloyd, M. C. V. Thom, M. H. Wermig, S. A. Woolf, J. A. S. Wright.

Part II.

At a meeting of the Council of the Royal College of Surgeons on March 9th, licences to practise dentistry were conferred upon the following candidates who have passed the requisite examinations and complied with the bye-laws:—R. S. Ryland, G. F. H. Bloom, C. L. Curle, H. Curtis, L. A. Morris, S. G. Smith, C. S. Southwell, M. G. Watson.

Appointments.

Medical School Appointments.

April–June, 1916.

Dressers and Clerks in Special Departments:—

a. *Throat and Ear, Genito-Urinary, and Children.*—Messrs. J. C. C. Howe, S. W. F. Underhill, H. T. Lamb.

c. *Eye and Nervous System.*—Messrs. J. O. R. Montocchio (Mr. Eason); R. S. Millar (Mr. Ormond).

Obstetric Dressers.—Messrs. O. St. L. Campion, A. W. A. Davies, J. T. T. Forbes, E. de Robillard, H. S. Wacher, W. J. Walters (Mr. Bellingham Smith); G. W. Heckels, M. C. Joynt, C. L. Odam, R. H. C. Pryn, G. E. L. Simons, H. I. Sterne-Howitt (Mr. Chapple).

Surgeons' Dressers.—Messrs. L. Gill, J. A. Berry, F. J. Harrington (Sir Arbuthnot Lane); E. F. Deacon, F. R. Leblanc (Mr. Dunn); J. W. H. Grice, S. M. M. Jabir (Sir Alfred Fripp); E. H. Bryant, H. N. Pritchett, E. C. Hinde (Mr. Steward).

Extension Medical Ward and Post-mortem Clerks.—Messrs. J. R. Cox, W. A. Hawes, A. Magill (Dr. Hale White); C. G. Coombs, S. T. Wong, W. R. G. Hearnden (Dr. Shaw); A. Bulleid, C. H. Laver, J. C. Gie (Dr. Fawcett); G. R. Hubbard, H. D. Apergis, G. H. Fitzgerald (Dr. Beddard).

Medical Ward Clerks (first three months).—Messrs. H. O. Long, C. R. Cade, A. A. Osman, A. L. S. Payne, A. G. M. Severn, W. H. Grace, H. G. Burford, A. R. Doyle, F. Young, W. H. Steavenson, C. G. Siggs, S. Wolff.

Assistant Surgeons' Dressers.—Messrs. L. S. Debenham H. Millett, C. Halstead, G. A. S. Shacklock (Mr. Fagge) W. A. Flynn, F. Caldecott, F. W. Reitz, R. C. W. Staley (Mr. Rowlands); N. Kamchorn, B. C, W. Simpson, A. Y. Massouda (Mr. Turner); C. W. W. Armstrong, J. Victory, T. Fernandez, G. Meadows (Mr. Hughes).

Surgical Ward Clerk.—Mr. C. L. Curle.

Student Demonstrator of Microscopical Pathology.—Mr. G. W. Heckels.

Pathological Assistants to the Demonstrators of Morbid Anatomy.—Messrs. G. W. Heckels, C. L. Odam.

Royal Navy Medical Service.

Fleet-Surgeon S. Croneen has been placed on the Retired List with a gratuity.

Royal Army Medical Corps.

T. E. Holmes to be temporary Major whilst employed at Bagthorpe War Hospital.

Temporary Lieutenant F. E. R. Laborda has been appointed temporary Captain.

The following to be temporary Lieutenants:—N. Garrard, L. G. Reynolds, A. Traill.

Temporary Lieutenants L. Pern and A. E. Clark relinquish their commissions.

Lieut. A. Neville Cox, R.A.M.C., has been appointed specialist for tuberculosis cases at the Kitchener Hospital, Brighton.

Lieut. D. Clewer, attached R.A.M.C., Dental Officer, Seaford, to be temporary Captain (February 6th).

Territorial Force, R.A.M.C.

Eastern Mounted Brigade Field Ambulance:—Lieut. V. M. Wallis to be Captain.

London General Hospital:—Capt. K. B. Clarke relinquishes his commission on account of ill-health.

West Casualty Clearing Station:—W. S. Richardson to be Lieutenant.

North Midland Field Ambulance:—C. M. Cooper relinquishes his commission on account of ill-health.

London Sanitary Company:—Lieutenants A. E. Rayner and C. D Edwards to be Captains.

Reviews, etc.

A new volume entitled "More Minor Horrors," by Dr. A. E. Shipley, is now in the press, and will be published by Messrs. Smith, Elder & Co. in the early spring. It is, in a sense, a sequel to the "Minor Horrors of War," a third edition of which is now in the course of preparation.

Those interested in the surgical advances made in the war will welcome a resumé of the subject. "Surgery in War," by Major A. J. Hull, F.R.C.S., R.A.M.C., is an attempt in this direction. Sir Alfred Keogh, K.C.B., has written the preface, and Lt.-Col. E. M. Pilcher, D.S.O., the introduction, while other contributors write on subjects with which they are specially conversant. Numerous X-ray plates and diagrams elucidate the text. The book will be published immediately by Messrs. J. & A. Churchill.

Sir St. Clair Thomson has passed for immediate publication a second and enlarged edition of "Diseases of the Nose and Throat." This text book has been rigorously revised and expanded by some 70 pages. A description of Suspension Laryngoscopy has been introduced into the new edition, and the chapter on Removal of the Tonsils has been entirely re-written. The new edition will be published next week by Messrs. Cassell & Co., Ltd.

The Cambridge University Press has undertaken the agency in Great Britain for two new medical journals, the first being *The Journal of Cancer Research* (quarterly), which will be the official organ of the American Association for Cancer Research. It will be the object of this journal to collect under one cover such contributions as bear in any way upon the general problems of oncology. It will, therefore, embrace studies which approach the subject from the individual standpoints of statistics, immunology, pathology, and inheritance. Not alone the experimental, but also the clinical and the therapeutic aspects of the problem, in so far as they have general application, will receive due recognition.

Among the earlier articles, already scheduled for inclusion in the first volume, are studies in the action of radium, on chemotherapy, and on the mechanism of metastasis. Thus, it will be evident that the scope of the journal makes a broad appeal to all those who are interested in the study of cancer, whether from the theoretical or from the practical standpoint. The first number will appear very shortly.

The other journal is *The Journal of Immunology* (bi-monthly), which will be edited by Arthur F. Coca, of Cornell University Medical College, and will be the official organ of the American Association of Immunologists and the New York Society of Serology and

Hematology. This journal will be published under the direction of an advisory board and an editorial board composed of the foremost American and English workers in this field. The personnel of the staff alone is an assurance that articles will appear by the most able and progressive scientists, while the contributions of the best-equipped laboratories in England and America will be regularly seen.

The subscription price for each journal will be 23s. net. It is the belief of the publishers and the editors that both journals will appeal not only to specialists, but to all medical students and practitioners.

Rugby Football.

UNITED HOSPITALS v. 3rd GLOUCESTERS.

After so much rain, Queen's Club Ground on Saturday, March 11th, was in unexpectedly good condition, and before it got very churned up the Hospitals made the best use of their time. In about half an hour they piled up 21 points, and during that time the Soldiers were bewildered and must have thought that the final score was going to be a bumper. But at that number the scoring stopped, and if the Gloucesters did not cross the Students' line, they had the satisfaction of, successfully from that point onward, defending their own.

Stewart was almost in in the first few minutes from a cross kick by Curle. From the ensuing touch the ball was thrown in, and Evans of Bart.'s dropped over the line neatly for Knight to goal. After this the Soldiers gained ground by touch-finding kicks, but the next score was soon forthcoming. The Hospitals' halves started passing in their own half, and Llewellyn, receiving, cut through and gave to Curle who, on reaching the full back, sent back to Llewellyn to complete a splendid movement. Knight again added the extra points. The next score was a try by Curle; this time Knight missed goaling. Stewart, who seems almost as fast as ever, now came along with a fine try; going through all his own and dodging at great speed, no one could touch him. Knight majorised. The speed of the Hospital men was the great factor, and they yet once again came along at top rate, Curle eventually booting across for Stewart to gain the try. The angle was most difficult for goaling, but Knight almost succeeded, his attempt hitting the upright.

Half time came with no addition to the total, nor did more points accrue all through the second half. The Gloucesters kept up rushing tactics, but nothing came of them and very seldom were they really dangerous. As for the students, they saw less of the ball, and with a comfortable lead seemed less enterprising than in the opening half which was packed full of really delightful football. Final score—United Hospitals, 3 goals 2 tries (21 points); 3rd Gloucesters, nil.

C. G. Ainsworth (London) (back); W. A. Stewart (London), R. V. Knight (Guy's), E. Llewellyn (Bart.'s), C. L. Curle (Guy's) (three-quarters); T. E. Micklem (Guy's), C. W. W. Armstrong (Guy's), E. A. Fiddian (Bart.'s), G. E. Kidman (Guy's), J. Shellswell (Guy's), D. H. Cockell (Bart.'s), D. D. G. Evans (Bart.'s), H. C. Joyce (Bart.'s), F. M. Mosely (London), S. W. Woodhouse (London) (forwards).

GUY'S v. R.N.D., PALACE.

With this match, played on March 18th at the Palace, our season closes, so it was fitting that it should close with a win, although a narrow one; but we had a very weak side out and thus may congratulate ourselves that the margin was not the other way. Many men who had scarcely seen a ball for two seasons turned out in sporting fashion, and at least two members of the pack had seldom, if ever, played Rugby before.

It was very heavy going, and the ball after about fifteen minutes' play impossible to kick more than a few yards. Still, our men managed to pass it in quite extraordinary fashion considering the conditions. There was one player, against us, who did not seem at all hindered by the ground, and that was Sub-Lieut. Paull, who played a jolly good game, and, as Becker will tell anyone, wanted a lot of watching. He gained the first and third try for his side. The scoring opened with a try to the R.N.D., and then passing by our three-quarters put Harrington in first and then Aspinwall. The play is difficult to describe, because so much of it was naturally close scrimmaging up and down field. One good piece of footwork on Leviseur's part sent Sidebottom in.

At half-time Guy's led by 3 tries to 1. No goals were kicked all through the game, though Harrington's attempts were very fine. During the second half Phillips treated us to some excellent dribbling, but our defence, somewhat weakly, let in the R.N.D. with two more tries. Their whole pack bundled over for one, and Paull got the second. Luckily with about five minutes to go, our three-quarter line came into its own again, Aspinwall just managing to cross by the corner. Score—Guy's, 4 tries (12 points); R.N.D., 3 tries (9 points). Much praise is due to C. L. Curle for the way he has managed to arrange matches, and in face of almost insuperable difficulties secure teams to play for us in the various engagements.

P. J. McEvedy (back); —. Aspinwall, C. L. Curle, C. C. Becker, F. J. Harrington (three-quarters); E. A. Leviseur, A. Bulleid (halves); C. W. W. Armstrong, J. Shellswell, E. A. Phillips, C. Caldecott, J. L. Gie, T. L. Heath, —. Jerwood, A. Sidebottom (forwards).

Births.

DAWSON.—On March 17th, at Ednam House, Willenhall, Staffs., the wife of Reginald B. Dawson, M.R.C.S., L.R.C.P., *née* Fraser, of a daughter.

PHILLIPS.—On February 12th, at Bethlem Royal Hospital, London, S.E., the wife of J. G. Porter Phillips, M.D., M.R.C.P., of a son.

Marriage.

HOLMAN—FOWELL.—On the 16th February, at All Saints, Leamington, by the Rev. Canon E. L. Jennings (cousin of the bride) and the Rev. J. A. Murray, Charles Colgate Holman, M.B., F.R.C.S., youngest son of the late Thomas Holman, M.R.C.S., to Violet Evelyn, only daughter of Col. N. P. Fowell, late R.A., and Mrs. Fowell, of Bedford Lodge, Leamington Spa.

Death.

PITTOCK.—On March 5th, George Mayris Pittock, M.B. Lond., M.R.C.S., F.R.M.S., of Winton, Canterbury. Aged 84 years.

F. A. K.

GUY'S HOSPITAL GAZETTE.

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Passim.

IN the previous issue of the GAZETTE we gave publication to a notice issued by the Central Medical War Committee, an organisation previously acting under the name of the War Emergency Committee, and whose methods are no doubt by now familiar to most of our readers. Judging by opinions expressed by many contemporaries, we may say that this body is hardly meeting with the unanimous support from the profession it would seem to expect; in fact, in many quarters its authority appears to be decidedly under challenge.

The fact that it sprang into existence without the mandate of the profession in general and the suspicion that it has too readily yielded to all and sundry official demands without due forethought and investigation have doubtless provided the chief reason for this unfortunate situation.

Unfortunate it is, in that the recent calling of men to the colours incontestibly causes an increasing demand upon the medical profession, for neither men in home camp nor men on the various fighting fronts can be left without the necessary medical aid. It is no way surprising to hear the War Office call for doctors repeated, and as matters at present stand this Committee exists as the only recognised organisation which makes any attempt to deal with the need and the only channel by which the requirements of the Army and the just treatment of the profession can be brought to the same survey.

Supposing that many expressed suspicions be well founded, that its origin and composition be not ideal, we remember that in these times we are called upon to accept many things from the cause of patriotism alone, and the Central War Committee seems likely to be among their number. However, we read that the Royal Colleges have officially joined in the task of supplying the needs of the R.A.M.C., and though very little is definitely known, it is understood that they are to work separately from the Committee, but with agreement and towards the same goal. Also it has heen stated that they will deal with cases affecting all Metropolitan hospitals and schools, while the Committee will deal with the country at large.

It seems ovious that two bodies cannot work efficiently over the same areas, and we look forward to the official description of their spheres of activity, for even recently we have seen in the daily papers a notice, this time through the medium of the Press Bureau, bearing the tone of a suggestion rather than an announcement of a permanent policy, and which again places the authority in the hands of the Committee. Thus at the basis of the whole matter lies the question. in the case of practitioners, of confidence in the Committee,

and in the case of the younger hospital men of more definition in policy and actual requirements. Especially would there seem room for more publicity and decision to all official proceedings and more information as to *exactly* which body is to hold permanent control.

An appeal to the Committee has produced the letter published later in this issue, and a mere enclosure of the now well-known circular labelled W. 10.

It is with the deepest regret that we hear of the death of Lieut. P. H. Berry, R.A,M.C., while with the Western Frontier Force in Egypt, in an attempt to save a man from drowning. The gallantry of his last action will be appreciated by all,

Since our last issue we have received a copy of the *Otago University Review* from Dunedin, New Zealand, with the hope that a regular exchange of periodicals should be instituted. We welcome this suggestion, and trust it will form an initial step towards a permanent friendship.

We would draw attention to a letter received from Mr. Montagu Hopson in an urgent appeal for support on behalf of an old Guy's man who is a candidate for admission to a home for incurables. Our readers will not hesitate to provide their required small but many times appreciated assistance.

To refer to one other letter received. The invitation to the present Exhibition at Prince's Skating Rink, Knightsbridge, where a small but apparently extremely efficient offshoot of Guy's may be seen in full working order.

Subscriptions towards the presentation to the retiring Janitor, Mr. John Morley, are still received by Mr. S. H. Croucher, at the Medical School Office. We sincerely hope men will not forget this small fund.

Letter received from Central Medical War Committee :—

Dear Sir,

In reply to your letter of the 27th inst., we beg to enclose copy of our circular W. 10, which explains our Enrolment system. You will find that the columns of both the *B.M.J*, and *Lancet* for some weeks now have been pretty fully occupied with explaining the plan, and I should like to direct your attention to a leading article which will appear in the *B.M.J.* of April 1st, which attempts to impress upon the medical profession what a fine opportunity it now has of doing a unique service for the country.

As regards the newly qualified men, they are of course expected, unless they are physically unfit for military service, to join the R.A.M.C. as soon as possible, and our information is that by far the great majority of them lose no time in doing so.—I am, yours faithfully, ALFRED COX,

March 29th, 1916. Secretary.

Papers by Guy's Men.

Lieut.-Col. A. W. Sheen, T.D., R.A.M.C. (T.F.): The case-recording of wounds in war.—*The Clinical Journal*, March 22nd, 1916.

E. Hyla Greves, M.D., M.R.C.P.: Clinical records from a physician's case-book.—*Ibid*, March 8th, 1916.

W. Courtney Lyne, L.D.S. (communicated by Montagu F. Hopson, L.D.S. Eng.): The significance of the radiographs of the Piltdown teeth.—*Proceedings of the Royal Society of Medicine*, February, 1916.

Kenelm H. Digby, M.B.: The measurement of diaphysial growth in proximal and distal directions.—*Journal of Anatomy and Physiology*, January, 1916.

Capt. C. H. Reinhold, R.A.M.C., I.M.S.: A lucky wound.—*The Indian Medical Gazette*, March, 1916.

A. T. MacConkey, M.B., B.C.: A plea for a collective study of tetanus.—*Journal of the R.A.M.C.*, March, 1916.

Major B. H. Hogarth, M.D., B.S., R.A.M.C.: Report on cases of albuminaria amongst British troops in France.—*Ibid.*

Lieut.-Col. A. W. Sheen, R.A.M.C.: The case-recording of wounds in war.—*Ibid.*

Lieut.-Col. H. W. Webber, R.A.M.C. (T.F.): Recruiting notes.—*Ibid.*

Capt. G. T. Mullally, M.B., B.S., F.R.C.S., R.A.M.C. (in collaboration with J. W. McNee, M.D., R.A.M.C.): A case of gas gangrene exhibiting unusual proofs of a blood infection.*The British Medical Journal*, April, 1916.

A. S. Erulkar, M.D., B.S., L.R.C.P., M.R.C.S.: Hexamine, its use and misuse.—*The Practitioner*, April, 1916.

Annual Report (1915) of the Electrical and X-ray Committee.

For submission to the Medical Committee.

ACTINOTHERAPEUTIC AND ELECTRICAL DEPARTMENTS.

During the year 1915 Dr. Hertz resigned his appointment of Medical Officer of the Electrical Department, and it was taken over by the Surgeon of the Actinotherapeutic Department.

As to result: the two departments have, to a certain extent, become merged into one, and the statistics are, therefore, included under one head. It will be seen by the numbers that the work of the department has increased by almost one-third. There is also an increase in the number of patients, but it is not so great in proportion.

The chief feature of the year's work has been the number of wounded officers and men who have been treated in the department. It has been found that their treatment requires more attention on the part of the nursing staff than usual. For these reasons the work of the department has been heavier than in previous years.

(Signed) C. E. IREDELL.

SURGICAL X-RAY DEPARTMENT, 1915.

During the year, 6,372 cases were examined. They comprise examinations for the following conditions:—

3,870 Fractures.
500 Bone Diseases.
383 Urinary Calculi.
277 Embedded Foreign Bodies.
247 Swallowed Foreign Bodies.
226 Unclassified.
219 Bismuth Cases.
95 Dislocations.
82 Injuries of Chest.
65 Dental Cases.
43 Cervical Ribs.

There is an increase of 347 cases on the grand total as compared with last year. Amongst the unclassified cases are a number of local anæsthetics, for the removal of foreign bodies, and general anæsthetics for the setting of fractures and putting on of plasters. Of the 383 urinary cases, 53 proved positive, calculi being seen on the screen first. In addition, 275 officers quartered in Stephen Ward have also been examined.

The original Coolidge Tube, purchased by the Hospital on March 5th, 1915, has been in use ever since, and during the year, 5,628 cases have been examined with it. The cost of tubes at pre-war prices to examine this number of cases would have been £132, and nearly double this amount at the present war prices. Therefore, taking the cost of the present Coolidge Tube at £24, the saving is somewhere about £230 in twelve months. This Tube is still giving as good results as when first installed.

(Signed) E. W. H. SHENTON.
H. N. ECCLES.

STATISTICS OF THE ACTINOTHERAPEUTIC AND ELECTRICAL DEPARTMENTS FOR 1914-1915.

Date.	Ringworm.	Alopecia Areata.	Lupus Vulgaris.	Lupus Erythematosus.	Rodent Ulcer.	Warts, etc,	Nævi.	Miscellaneous Skin Diseases.
1914	572	99	21	7	27	89	116	38
1915	591	108	36	7	33	109	147	32

Date.	Growths.	Diseases of Joints.	Miscellaneous.	Nerve Lesions.	Muscle Testing (without treatment).	TOTAL.
1914	91	86	190	103	—	1,439
1915	99	85	306	136	10	1,699

GRAND TOTALS.

Date.	Patients.	Attendances.	Treatments.
1914	1,439	22,898	32,518
1915	1,699	30,125	42,153

(Signed) C. E. IREDELL.

MEDICAL X-RAY DEPARTMENT, 1915.

During the year, 1,266 patients passed through the Department. 580 of these were In-Patients; 686 were Out-Patients.

On these, 2,062 examinations were conducted, as follows:—

1295	were	examinations	of the alimentary tract, with opaque meals.
392	,,	,,	,, chest.
144	,,	,,	,, urinary tract.
231	,,	,,	other than those mentioned.
2062			

The number of examinations is less by 948 than in 1914, and this may be accounted for by the loss of one medical ward and by the absence of the Medical Registrars, the work now being done almost entirely in the afternoons. New apparatus has been installed and has worked continuously and satisfactorily.

(Signed) W. LINDSAY LOCKE.

Night Duty: War-time.

It's a queer kind of life we live,
This creeping about in the night,
Keeping awake when you want to sleep
And hiding all day from the light.

It gets at one's nerves sometimes—
Listening the sound of their breath,
Cautiously touching the fluttering pulse
To know if it's sleeping—or death.

Watching for red blood-stains
Gripping the artery "some,"
Sending the orderly flying for help—
Why doesn't the M.O. come?

Then in the dead of the night
Word comes, "The wounded are here";
Open the door for the stretchers to pass,
Bring them in battered and blear,

Fine men they were, straight and strong
Only a few hours before—
Now they are huddled heaps, groaning in pain.
This, then, is the glory of War!

Such is the life we lead
Tending the sick in the night,
Tired when the morning comes along,
Sleeping all through the light.

K. J. C.

St. J. A. B. Hospital,
Army P.O., S. 11,
B.E.F., France.

Correspondence.

To the Editor of Guy's Hospital Gazette.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

Dear Sir,—I was very interested in Capt. Ormond's article in your last number on "Concussion Blindness," as I have had to deal with quite a number of cases similar to those that he quotes, and up to now the treatment of the condition has puzzled me considerably. Treatment by hypnosis seems to have been exceedingly successful, and, therefore, one was rather disappointed not to learn more in detail how the treatment was carried out. Capt. Ormond, after describing how the men were taken singly into a dark room, told to keep their eyes shut, and to think of something pleasant, etc., then says merely "we then used the usual methods of inducing hypnosis." One would like to know what are the usual methods of inducing the partial hypnosis required; whether every patient can be subjected to such hypnotic suggestions, and whether any medical man can carry out such treatment with much hope of success without previous knowledge and experience of such matters.

In another place I see the remark, "There is no difficulty in differentiating them from malingerers, as they pass through long periods of mental distress." In my experience one has often had great difficulty at a single examination in Out-Patients in deciding whether such patients are malingering or not, for all their symptoms are often entirely subjective, namely, photophobia, forcible closing of lids, rolling up of eyes, etc., and, moreover, proof of their inability to see rests entirely on their word. Examination usually shows no injection of the conjunctiva, pupils reacting normally, and when one is able to get a view of the fundus it appears quite normal, and often there is no serious error of refraction. One has seen several cases exactly parallel with those described in this article, men whose amblyopia has followed shell explosion, but one has also seen men with exactly the same symptoms who have never been in or near the firing line, and these are the men particularly in whom one has difficulty in deciding whether or not they are genuine.

Another symptom I have noticed, not mentioned by Capt. Ormond, is, that although their sight is bad during the day, after dark they say they can see nothing. This has so frequently been told me that I have, when possible, examined peripheral parts of the fundus, but have never seen any pathological changes there to explain the symptom.

Cases of this sort surely have many features in common with a type very clearly described in an article in the *British Medical Journal*, 4th March, 1916, by C. F. Harford, M.D., and commonly called miner's nystagmus, though often no nystagmoid movements are present. I have recently seen a number of soldiers who, before enlisting, had been miners, and who were now sent to me for defective vision, which one looked upon as a functional amblyopia and who had much the same symptoms as had Capt. Ormond's patients, but generally without nystagmus. One wonders whether this class of patient could be relieved in the same satisfactory manner by hypnotic measures.—Yours,

14, Thorpe Mansions, G. MAXTED.
Norwich,
31*st March*, 1916.

Dear Mr. Editor,—I wonder if you have heard of "The Casualty Clearing Station," in *The Daily Mail* Active Service Exhibition at Princes Rink? The C.C. Station is run by Guy's under Miss Swift and Lady D'Abernon. We charge 6d. for our tent, and yesterday made £23, so you can imagine the success it is. An old Guy's man is showing the X-rays off in the afternoons and evenings, and we are assisted by a squad of Orderlies from Millbank who bring four convalescent patients to put in our beds. But, please, all of Guy's and you, Mr. Editor, come and visit it yourselves, and we will show you round.—Believe me, yours truly,

MILLICENT BROWNING.

35, York Mansions,
Battersea Park, S.W.
26*th March*, 1916.

Dear Sir,—I have received numerous letters of inquiry from his friends as to how P. H. Berry met his death. The following are a few particulars about the latter part of his career which I feel very many of his contemporaries are anxious to know:—

Percy Berry left general practise to join the R.A.M.C. on May 1st, 1915, and shortly afterwards left Aldershot for Alexandria with a draft. He was appointed to the hospital ship "Assaye," and was engaged in transporting the wounded from Gallipoli through the summer and autumn. Subsequently he was attached as M.O. to the Berkshire Yeomanry, and with them joined the Western Frontier Force of Egypt in the campaign against the Senussi. In this he was completely happy, and declared that he had at last found the ideal form of warfare.

The official account of his death states: "On 10th March, at Berrani, seeing man drowning, plunged off rock into heavy surf with all clothes on to rescue. Immediately big wave broke over him, and he disappeared. Body found five hours later with large wounds, head, apparently ante-mortem. Buried, 11th March, at Berrani, with military honours."

All who knew him well will recognise how typical the end was of the man.

Berry was too well known to require any attempt at description in a hospital paper.—Yours faithfully,

1, Mildred Avenue, V. GLENDINING.
Watford, Herts.
24*th March*, 1916.

Dear Mr. Editor,—I have read with pleasure the articles on "The Position of Women," by G. H. F. G. He is a skilful manipulator of statistics, and has the art of going straight to his point. He shows that the limitation of the family is becoming more and more apparent as parents realize that fewer children mean greater comfort. The labouring man sees the luxury of the well-to-do and strives for it. He also sees the discomfort of large numbers of his own class, and though, no doubt, considerations of comfort and luxury are the chief cause of small families, the active discomfort of a large family has also to be seriously considered by an intelligent working-man.

The surroundings of the poor are deplorable. The writer states that if we were practical we should adopt some simple measures to remedy this, but does not suggest any. May I emphasize one aspect of the case. It is made abundantly clear from his facts and figures that the children of the poor are unhealthy. Now unhealthy children are a constant source of worry and difficulty to the mother and of intense irritation to the father, whereas healthy children are comparatively easy to rear. It will be agreed that a large proportion of poor women feed their own children, and so give them a fair start in life. After this stage is passed the children come under three influences: ignorance, crowding, and dirt, and of these the two latter are the worst.

The prevalence of dirt among the poor is due to the lack of the means to keep clean. The houses of the Borough are mostly disgraceful—to the landlords! No extern has ever seen a bath in the houses he visits. The author of "Across the Bridges" laments the lack of imagination that led the builders of the early model dwellings for the poor to leave out bathrooms. And even if there were bathrooms, the expense of heating water is far too great to allow of its frequent use; not only so, but all the accessories of the bath need money which is inevitably spent on the necessaries of existence.

The provision of dwellings with adequate means for bathing, for washing of clothes, is of more importance to the state than the whole of the Insurance Act (excluding the maternity benefits).

I make no excuse for introducing this question of housing into your paper, for those at the great London

hospitals are as well, if not better, able to judge of its importance than any other section of the community. As G. H. F. G. says, "What, one may ask, do they know of Mile End (or the Borough) that only Mayfair (or Fleet Street) know?"—Yours, etc.

March, 1916. E. C.

No. 3 Combined Field Ambulance,
Nasariyah,
I.E.F.D.,
26th February, 1916.

So far in the Gazette there have been no letters from Mesopotamia, so I thought the following might be of interest. I have been up here since September, with this ambulance, and until the last three weeks had not heard a shot fired. Though we are called an ambulance we are much more of a general hospital, as we can only send cases away from here with great difficulty, and a four days' sail in a country boat, which is about the average time to Basra, is not good for those who are bad. At the same time we are enjoying none of the advantages of a larger unit, and my theoretical 25 beds have never had less than 40 occupants, and have been up to 75.

The chief diseases are colitis, jaundice, malaria, and chronic ulcers. The colitis does not, as a rule, react to emetine, but in time quiets down, or not, as the case may be. The jaundice, and about 15 per cent. of the troops at least have had it, is usually a very mild affair and gives no trouble. The malaria is rather interesting, as so far it has almost all been imported; in only one case has a man had malaria here who has not had it before. It is a benign tertian, as a rule. The Turkish doctors here say that only in April and May is there malaria here, but that then it is very bad, and a malignant form, too. The ulcers are interesting in that they are not true oriental sore, which is not, I hear, found except in Bagdad and the large cities. We have a microscope up here, and, examining these sores I have seen no signs of Leishman-Donovan bodies.

We had our first bloodshed in January when a reconnaisance sent out from a small camp was held up by Arabs. They got clear alright and did a fair amount of damage. The wounded from that show had a poor time, six miles into camp all on stretchers, and then 14 miles back from the camp to Nasariyah, again on stretchers.

There are no roads, and the whole place was deep in mud. The wounds were mostly with ·450 lead or Martini bullets, very large and full of clothes if they got the chance; however, on hypertonic saline they all did very well. After that we had more trouble during our retirement from the camp, the wounds were mostly of the same kind, and mostly did very well, and we got rid of them down the river fairly soon. Just now the weather is very good, only 72° by day, and not very cold at night; however, it is warming up, and in the last week has changed from winter to summer.

As to the country, I doubt if "E." could get romantic about it, even though he could see Ur of the Chaldees from the door of his tent, as I can, and though the whole place reeks with history which was ancient long before Vulcan limped lamely from Lemnos. And as to the Arab—he is a swine of the first water.

T. S. KEITH,
Capt. R.A.M.C. (Temp.)

Dear Sir,—Again I am waiting for a midnight or early morning train. Amongst my correspondence I came across this article, that I intended to type. I have hesitated to send it as it seems rather feeble, however it might as well reach your editorial eye as be consigned in my waste paper basket. I am in the midst of a most awful rush—worse than I ever knew in twelve years Rhodesian experience, and am wanted in places a few hundred miles apart. I really am nearly at the end of my tether, but trust to a calm after the storm.

I am sending you a copy of the Gazette—You will see my name in it—I send it for I have seen many men of my year are at the front. The defence force for service anywhere in the territory is all I can do. My job is undoubtedly here. Still I should like perhaps some of the men who remember me to know I am doing my bit, though it is far from wars' alarms at present.

Lusaka,
N. Rhodesia,
9th March, 1916.

Yours faithfully,
P. H. WARD.

An Urgent Appeal.

Dear Sir,

May I make use of your columns to enlist the sympathy and support of your readers on behalf of an old Guy's man who is a candidate for admission to the British Home and Hospital for Incurables at Streatham, S.W. Mr. B. G. Tasker, L.D.S. Eng., who qualified from Guy's in 1896, and subsequently practised at Brighton, is in the unfortunate position of being totally and permanently incapacitated at the early age of 42 by arthritis and chronic bronchitis. To men of his year, both medical and dental, he was well known, and I am quite sure that the comradeship which exists between all Guy's men will cause them to rally to his support in the distressing circumstances in which he is placed. Votes will be gratefully received by the candidate at "Inverkip," Chase Court Gardens, Enfield, or may be sent direct to the Secretary, 72, Cheapside, E.C.—Yours very truly,

64, Harley St., W. MONTAGU F. HOPSON.
2nd April, 1916.

A Sanitary Section at the Front.

By Captain G. LESLIE EASTES, Royal Army Medical Corps (T.F.)

[With acknowledgements to *R.A.M.C. Journal.*]

The war establishment of a sanitary section consists of a Commandant, either Captain or Lieutenant, two Sergeants, one of whom is a Staff-Sergeant, two Corporals, one Lance-Corporal, and twenty men, all drawn from the Royal Army Medical Corps, Territorial Force, and attached to the section are two drivers from the Army Service Corps. The equipment includes two box sterilizers (current steam), one water clarifier and sterilizer, numerous brooms, watercans, pails, and flagpoles (to mark the position of latrines), with some Mackenzie sprays, spades, pickaxes, butchers' and carpenters' tool boxes, and three circular tents; for transport and forming part of the equipment either a motor lorry or general service wagon, according to the terrain in which the section is going to operate. Concerning the general service wagon it may be remarked that its carrying capacity is insufficient and that the addition of a maltese cart is indispensable, and the number of horses or mules and of drivers must be correspondingly increased.

With reference to the personnel, as stated above, all belong to the Royal Army Medical Corps, Territorial Force, but the Commandant need not necessarily be a member of the medical profession, provided he has some sanitary qualification, *e.g.*, sanitary engineer or architect. Nevertheless, a medical qualification is very desirable for many reasons, not least being that the Commandant is then able to treat the minor ailments and casualties of his men and thereby keep his ranks intact, a desideratum difficult of attainment when the sick have to report to the medical officer of some other unit.

The rank and file are selected as far as possible from employees of sanitary authorities and firms, and should include one laboratory assistant. The composition of my own section might serve well as a model. It includes four qualified sanitary inspectors, three Borough Council employees, skilled in road and drainage works, one builder, one skilled disinfector, and one carpenter. The remainder had no special pre-war sanitary experience, but are intelligent young fellows, who speedily acquired knowledge of the work required of them. As far as military considerations allow, non-commissioned rank should be given to the sanitary inspectors. Two men should be trained being going abroad as cooks, another as orderly clerk, and another as quartermaster. The laboratory assistant, if obtainable, will be of most service if he has been trained in an analytical laboratory.

The Commandant has a difficult and arduous post to fill, as he combines in himself the functions of commanding officer, adjutant, medical officer, quartermaster, orderly officer, paymaster, and censor, and is, therefore, never off duty. My experience shows that it would be advantageous, under the conditions of active service, for the Commandant to have a junior officer, who would relieve his senior of much of the routine sectional work. Again, the Commandant may find his job a very solitary one, if he is so situated that he cannot join a mess, as was my position for nearly three months.

Outside his own section the Commandant, as may be surmised from the junior rank assigned to him, has no executive power, but is solely advisory and critical. It is even doubtful whether he is a "sanitary officer" in the sense in which the Army uses the term, the point having been left ambiguous, possibly purposely, as the formation of sanitary sections is quite recent, and the test of war is required to demonstrate the justification for their existence. Again, a section may find itself under the control of a D.A.D.M.S., an officer of field rank, who may be appointed as a specialist sanitary officer to the base in which the section is working.

In pre-war days it was laid down that sanitary sections are lines of communication units, but after the various bases and intermediate bases had been supplied with sanitary sections the idea was conceived of allotting a section to each division. But my own section, though originally a divisional unit, has also acted as an intermediate base and advanced base unit within a period of five months, and this has militated against its proving itself, but, of course, has widely extended its experience. The constant changes have so far never allowed it to complete its work in any one sphere, and with each change has come a different set of conditions to which the section has had to accommodate itself, and a different personnel with whom to make itself acquainted. No doubt, a section which has been definitely allotted either as a line of communication or divisional unit, is better able to give good results than one which, like my own, is placed under a new set of circumstances every two months. At present the section is stationed at an advanced base in the Mediterranean within a mile of the firing trenches, and there I trust it will be allowed to remain.

Certain of the sections have developed special functions, others work on a broader basis. These differences depend mainly upon the proximity of the district occupied to the firing line or upon special local conditions, and to a less degree upon the training or aptitude or proclivities of the Commandant. For example, some sections have specialized on pro-

vision of bathing facilities or water purification, whilst others seem to be hardly more than scavenging squads. The theory underlying the formation of a sanitary section is that it is a skeleton to be filled out with unskilled labour to form a large body of workers either (1) in a district which is occupied by successive bodies of troops or where sanitary works are entirely lacking or very crude and require to be developed, or (2) in the case of a divisional section, as a body of overseers or inspectors.

At the advanced base I was given command of a second section, much reduced in numbers when I took over, the Commandant of which had gone sick. I found a foul area closely packed by men and stores, etc., the men living in dug-outs; the uncovered ten feet deep latrine trench system in use, water supply restricted, much diarrhœa amongst the troops, lax sanitary supervision; clothes disinfection though urgently required being carried on quite spasmodically, and the whole area under occasional shell fire, with stray bullets wandering overhead at all hours; but sea bathing was possible and contagious diseases practically negligible. At the time of our arrival the considerable task of removing men and stores from the crowded to a more spacious area had been taken in hand and was being prosecuted with energy. Transport was naturally limited, but was being improved. Almost everything requisite for sanitation had to be imported or improvised. Here naturally was scope for wide and strenuous activity, and we became veritable artists in improvization.

As the latrine areas were nearly used up, and as the question was represented to me to be urgent, I at once set to work to provide for the new area a latrine system working on the destruction principle, and upon the public lavatory system, endeavouring to abolish the regimental latrine. To this end sites were selected where gullies converged, or where troops congregated, *e.g.*, near pier-heads, supply depots, etc. Upon each site seat latrines accommodating ten men and two officers were constructed, cresol drums, supplied with wire handles, utilized as pails; underground fly- and stench-proof urinals were constructed, triangular incinerators, having a sloping top and chimney of stones and mud were built. For the grid of the latter, iron bars from wrecked lighters, Turkish bayonets, etc., proved useful. Each latrine area was also provided with a large tub for reception of dry refuse from the nearest lines. This and the addition of damaged hay (which I commandeered) to the well-oiled pails, formed an inflammable material easily consumed by the incinerators. Men were instructed to urinate before using the pails and quickly accustomed themselves to the system. Crude petroleum was used for cleansing the pails, and a liberal sprinkling of chloride of lime over the area diminished the fly plague. One lesson I have learnt is that in dry climates, cresol or other aqueous solutions, except formaldehyde, are useless against flies. Upon the sloping top of the incinerators fire-plates were to be laid before the wet weather set in; this, with the addition of a cowl to the chimney it was hoped would permit incineration in the rainy season. Later, I intended to add two Serbian disinfector barrels to each latrine area. The whole site was placed in permanent charge of one man, whose duty it was to see that separate urination before defæcation was observed, to cleanse and oil the pails and incinerate the contents. In carrying out these constructional works, the men, who had been Council employees, were most useful.

The next step was to divide the beach areas into districts, approximately equally peopled, and place a man of the sections in charge. His duty was to acquaint himself with the location of each dug-out, to inspect daily and to report irregularities to me. Officers commanding units were requested to see that night urine tubs and wet and dry refuse bins were established in their lines: the night urine tubs to be emptied every morning into the underground urinals and the contents of the dry refuse tins emptied into the large refuse barrels placed in the latrine areas.

The Thresh disinfector was started and kept in continuous action by appointing three squads of two men each from the sanitary sections. These squads worked eight-hour shifts; fortunately each section contained one man who was an expert disinfector.

Then the water problem was taken in hand. The water is brought mainly in lighters and pumped thence to tanks placed in various spots. From these tanks it is distributed in galvanized water vessels to the troops. Arrangements were made to allow each tank to be thrown out of action in rotation, so that it might be cleansed, and two men were detailed for this particular work. I was just taking up the question of cleansing the water-vessels and the men's own water-bottles when I had to leave. I found that there had been no systematic cleansing of these articles and men were to be detailed for this duty.

Finally, there was the problem of flies and lice in various quarters, *e.g.*, dug-outs, stores, staff-quarters, etc., etc. Fortunately, I found a supply of vermorel sprayers and could spare one or two men for this work. In this way practically all the men of the two sections were appointed to some special duty, and consequently each could go about his work without having to be specially detailed from day to day.

At all times there were certain other duties which fell to the lot of the sanitary sections to perform. Dead mules to be towed out to sea, by arrangement with the Naval Transport authorities, but we supplied the beach party and also the butcher, whose unpleasant tesk it was to rip open the animals at sea to ensure the carcase sinking. Generally, this duty had

to be performed under cover of darkness. Then there were fatigue parties allotted to us to help clear up the mess which still littered the ground, much of it dating back to the original capture of the various gullies. For these parties the sections supplied the supervision. All that was inflammable and unusable was burnt.

One of the most difficult items to deal with is the enormous and ever-increasing number of empty tins, with which the British Army is always hampered. After incineration these were stamped flat and thrown into abandoned and disused dug-outs and saps, but as soon as all these are filled, the labour of digging pits will have to commence again, unless arrangements can be made to procure two false-bottomed lighters to convey the debris out to sea. Certainly the working of this system would present difficulties in heavy weather, but I do not think these difficulties insuperable, if the Naval Transport authorities cordially co-operate.

The last problem I had for solution was the provision of hot baths in winter. With restricted fresh water supplies and an area under shell-fire this is certainly a difficult matter. I put forward the suggestion that canvas baths similar in all respects to those which form part of an officer's equipment should be procured in large numbers, flying column kitchens constructed for the heating of water in cresol drums, and I had hoped that the rainy season might present us with sufficient water in the wells dug by the sappers to allow from three to five gallons of water per man. Three would be sufficient, five ample, to allow men to have a luxurious hot splash-bath, and by the erection of shelters in the various gullies to which water from the wells could be taken in the water-carts, which are on the scene, I considered that the problem would be solved. So far, I have not heard what reception the suggestion has met with.

And now a few words of advice to Commandants who have not yet left home. Upon arriving at the scene of operations, report to the superior officer under whom you will have to act. This will probably be the D.A.D.M.S. Also consult with the C.R.E., as it is essential to secure the co-operation of the Engineers. Get yourself, if possible, attached to a mess. Learn all that is known of water supplies, drainage, infectious diseases, and other sanitary matters, and go over your district thoroughly. Having digested the information obtained, assign definite duties to the men of the section, and divide up the area into relatively equal subdivisions, using space or population as your basis of division, and place a man in charge of each sub-area.

One last word and I have done. I do not wish it to be thought that all the various sanitation works I had in hand were carried through to a successful conclusion, because I left owing to sickness, before that was possible. But all had been put in train, and I trust that my successor will have found it easy to complete the works commenced. My task was lightened and rendered a pleasure by the very special favours extended to me by my chief, whose interest and kindness I can never requite.

Pass List.

Society of Apothecaries of London.

At the examination held recently the following candidates were successful:—

Surgery (Sections I. & II.)—H. M. Gray.
Medicine (Sections I. & II.)—E. N. Glover,
Forensic Medicine.—E. N. Glover.

H. M. Gray received the Diploma of the Society entitling him to practise medicine, surgery and midwifery.

University of Durham.

FACULTY OF MEDICINE.

At the third examination for the degree of Bachelor of Medicine held recently, Harold Ivan Sterne-Howitt was approved in Materia Medica, Pharmacology, Medical Jurisprudence and Public Health.

Royal College of Surgeons of Edinburgh.

FIRST EXAMINATION IN DENTISTRY.

At the recent examination Cayetans Bethancourt was approved.

University of London.

M.B. EXAMINATION.

PART I.

The following candidates were successful at the last examination:—St. George Bernard Gray and Edwin Frank Deacon.

PART II.

J. V. C. Braithwaite, W. M. Brown, L. Burville-Holmes, M. Cohen, E. E. D. Gray, G. Hume, R. C. B. Ledlie, H. T. Le Vieux, G. Massie, W. W. Payne, S. Rosenschein, C. H. St. John.

Birth.

WILLIAMS.—At Richmond House, Buckley, Flintshire, on February 8th, the wife of Owen E. Williams, M.R.C.S., L.R.C.P.—of a son.

Marriages.

BENTLEY-SCOTT.—On the 28th March, at St. Mary's, Kennington, Kent, Richard John Bentley, M.B., B.S. Lond., of Northend, Ashford, to Ida Mildred, eldest daughter, of Major H. W. Scott, Lancs. Fusiliers, of Temple House, Kennington.

FRANCIS—GRENVILLE-LEVASON.—On the 8th March, in the Ladye Chapel, Hereford Cathedral, by the Rev. Geoffrey Turner, Rector of Medley (patient and friend of the bridegroom), assisted by the Rev. Capel, Vicar of the Parish, Reginald Cyril Herbert Francis, M.D., B.S., L.R.C.P., M.R.C.S. Eng., of 12, Castle Street, Hereford, third son of Dr. George P. Francis, J.P., Brecon, to Iris Daphne Katherine, second daughter of Peyton Grenville-Levason, Esq., of 12, Bridge Street, Hereford.

A State Medical Service.

THE LESSON OF THE R.A.M.C.

It would be arguable, apart, of course, from the somehow good which the poet predicts as the final end of ill, that the war has done more for the working classes of England than half a century of tentative social reform. Never, probably, in the course of our island story have they had so much to eat, been so free from anxiety, and in the case of the section of our industrial population now in the army, at least, so well clothed or doctored. The paternal care of the Government for its soldiers, altogether admirable as it is, would have met in peace times with the embittered opposition of that very influential class which holds any attempt at remedial work an insidious pauperization of the workers. Consider for a moment the wrath caused by such simple measures of social justice as the feeding of starving school children, old age pensions, and the Insurance Act—half-hearted as that measure was, and contrast it with the account published in the *Times* of about a fortnight ago by a Canadian observer of the amazing organisation and equipment of the R.A.M.C. in Flanders, where trained specialists, aided by all the devices of modern science, deal promptly and effectively with the casualties which take place a few miles away. Here, we are told, half a mile behind the firing line, dental mechanics are busy with their dentures, surgeons of world renown are working night and day for a sixth of the payment their services would command in civil life; an outbreak of typhoid in the trenches is followed by a rigid inquiry on the part of the sanitary officers; the regimental M.O. sends a case of trench feet to the base with a letter of abject apology for his carelessness. What an ideal—and what a moral! Apart from the adequate treatment of wounds, fevers, etc., directly arising from the conditions of war, the medical examination on enlistment revealed many slight defects which must have seriously impaired the efficiency of the individual in private life. Herniæ, unsuspected or insufficiently trussed, varicose veins, hydroceles, slight deformities of all kinds, which could be relieved by operative treatment; carious teeth, with their inevitable digestive sequelæ, minor defects in eyesight, enlarged tonsils, all came under the scrutiny of the examining doctor, and, since this was a matter, not of economic, but military efficiency, the man was either enrolled and recommended for treatment within the army, or told that he could not be accepted until his defect had been rectified. The work that Guy's, for instance, has been doing in this way is well known to my readers. The effect of all this organization upon the health of our armies has not been far to seek. Never in any war have the troops been so free from epidemic disease, nor when wounded been rendered fit for service in so short a time or in such large numbers. Without accepting Germany's claim to return 92 per cent. of her wounded to the firing line, there is reason to believe (whilst for obvious reasons the precise figures are not available) that we return from 86—88 per cent., and that only about 3 per cent. of the total casualties are fatal. The physique of the men after months of arduous fighting is little short of marvellous.

Here is an example, then, of what can be achieved even under abnormal conditions, by means of organization and the freest facilities for expert treatment of all kinds. Let us turn for a moment to the conditions prevailing in pre-war days — conditions which the war has aggravated a thousand-fold—amid our vast industrial population.

Excess Sickness under the Insurance Act.

The most striking fact which the first year's working of the Insurance Act brought to light was the vast amount of sickness in excess of the actuarial calculations. This excess was, as everyone knows, mainly in the women's societies. In some the excess amounted to as much as 100 per cent.; the average was between 25 and 50 per cent. In a year of exceptional prosperity and at least average healthiness, the deficit amounted to £70,000. This excess was due not, as was at first explained by the Commissioners, to malingering and lax administration, but to a very real and altogether unsuspected amount of ill-health among the classes—the submerged tenth, if you will—now for the first time dragooned into compulsory registration and doctoring, and should give one furiously to think. The Friendly Societies—notably the Manchester Oddfellows—upon whose sickness experience the Government calculations were based—touched only the more prosperous fringe of the industrial classes. Many were in receipt of incomes over £160 per annum and, therefore, not insurable under the Act; others were old members whose improved financial condition did not compel them to avail themselves of the benefits, but who for sentimental or other reasons continued their subscriptions. These and other more technical reasons made their figures, as a basis for the new mass of insured persons, wholely unreliable. "The new fact that stands revealed," says the Report of the Fabian Committe Inquiry, "is that, under the stress of modern conditions of employment, practically all groups of industrial women wage earners, far from having a sickness experience approximately equal to that of men (as the Government actuaries, whilst disclaiming responsibility, actually assumed), have one very considerably in excess of men." It will, I think, be generally granted that there is little conception of the low level of health at which the poorest classes of the community exist. I have in previous articles

shown the profound relation of this to such questions as infantile mortality and maternal ill-health in the period of pregnancy.

The Failure of the General Practitioner.

Without discussing in any detail the vexed interpretation of the "adequate treatment," left undefined in the Act, it must be evident that the treatment afforded to the insured has been of necessity inadequate. It has been the experience both at this and other hospitals that there has been practically no reduction in the number or change in type of the cases treated. Apart from a certain distrust, not unnatural, perhaps, of the panel doctor, whom the patient believes (quite wrongly) is on the panel simply because he cannot obtain a practice by other means, the vast size of the panels and the consequently limited time at the physician's disposal for examination and considered diagnosis, the rigid limitations as to cost of drugs which can be prescribed, the absence of any provision readily accessible for modern chemical and bacteriological tests, all go to make the panel system as a national scheme for medical attendance a ludicrous failure. It is not the fault of the much-maligned G.P., who almost invariably does his best under very trying circumstances, but that of the circumstances themselves. At the best of times the position of a G.P., even in good-class practice, is far from enviable. After five or six years of study in a general hospital—after which he may or may not take up qualified resident posts, he goes out to compete with his professional brethren in obtaining the confidence (and shekels) of the lay community. Hitherto his work has been under constant expert supervision, and pronounced good or bad by men competent to judge and advise. But the moment he starts his practice in the outside world he stands or falls by the *criteria*, not of his professional *confrères*, but of members of the very class whom it is his duty to attend. He gains the enviable reputation of "clever," not so much by his professional ability as by tricks of manner, popularity, tastes, amusements, recreations, which are *comme il faut*. Whatever commercialized competition may do in the industrial world, it works nothing but harm in the medical profession. Apart from professional rivalry and social expenditure, the question of practice only too frequently becomes a question of fees. The sixpenny and shilling dispensaries recoup in quantity what the three-and-sixpenny and five shilling doctor makes by exclusiveness. The lower the fees the lower the level of efficiency. Moreover, the strenuous conditions of competitive practice make it extremely hard for the medical man to keep abreast of modern scientific advance, in spite of the meetings of local societies and the excellence of medical periodicals. Night work, which is almost obligatory, is a further bar to real efficiency.

The Hardships of the Middle Classes.

For the poor and for the rich competent medical attendance is always possible, though for the former a matter of considerable inconvenience. On the plea of poverty they can always claim the best treatment that modern medical science affords. Yet the most superficial observer knows that for the countless thousands of the small shopkeeper and poorer professional classes, free specialist treatment is just as necessary as for their poorer or their richer brethren. Nevertheless, the restriction of the hospitals to the really necessitous places this most important class under an altogether unfair disadvantage. It is little wonder that they make use of all kinds of subterfuges to obtain treatment, which the present scale of consultant fees would place altogether beyond their reach. At any big general hospital they see the latest products of science ready for the service of any poor man who cares to apply, but they themselves are, perforce, to be contented with such treatment and nursing as can be carried out in their own homes, at infinite inconvenience, danger, and needless expense. Moreover, the co-ordination between specialists, such an essential feature of modern hospital work, is altogether impossible to any moderately prosperous member of the middle classes. The most, as a rule, he can hope to attain to, is a hurried consultation between two G.P.'s, neither of them in any degree specialists, or a brief five minutes with an overworked consultant, who has never seen the patient before and probably never will again.

Lack of Hospital Accommodation.

The crying need, obviously enough, is increased accommodation in government-supported hospitals. At the present moment, incredible as it may seem, there is no complete medical survey of the hospital beds available to the general public throughout the kingdom. Apart from tuberculosis and notifiable infectious diseases, however, the figure for London and the adjacent counties seems to be two beds per thousand of the population. In France, by the law of 1851, such a proportion is compulsory, and in Germany the figure for urban districts is 5, and in rural, 3 per thousand. Leaving aside London, the best provided counties have only between 1 and 2, whilst in 19 the figure falls below 1 bed! Further, in many cases there are long lists waiting for admission, the patients often receiving sickness compensation over lengthy periods before a bed can be provided. In others, recommendations are required from subscribers or governors, or a payment of 2s. 6d. to 30s. a week. Railway fares, too, are an important consideration in cases of the extreme poverty of many sufferers. All these difficulties render the sickness benefit payable under national insurance far more protracted than it would be were treatment and accommodation promptly available.

The Remedy.

At present, as Dr. Lawson Dodd, has pointed out in an interesting paper on the subject, the only persons who get expert curative treatment are the pauper, the criminal, the lunatic, and the millionaire. The result, as any working-class doctor will tell you, is shown in our disastrous annual harvest of preventible mortality. In any large London general hospital lies the nucleus of a very perfect organization to remedy this. That it is inadequate from a numerical point of view is due to the fantastic assumption that the hygiene of the nation is to be left in the hands of charitably minded millionaires. Socialist finance will probably reduce the number of millionaires, but it will regard the charge for hospital accommodation as a most necessary form of national insurance against sickness to impose upon the people. There should be, as a basis, an elaborately equipped clinical institute in every centre which had within a radius of twenty miles a population of 50,000 souls. Every facility should be afforded by it for the immediate diagnosis and free treatment of all cases sent by practitioners residing within the area. Further, compulsory courses should be organized, as in the Naval and Military Services to-day, which every general practitioner would be obliged to attend at periods varying from two to five years. In close connection would be hospitals manned by a staff of *paid* specialists, providing, as a minimum, five beds per thousand population, and open to all, independent of income or social status. In control of this would be appointed a Minister of Health, upon whom the responsibility for the health of the nation would fall. It would be his business to inquire into any marked falling off in efficiency of specialized districts or classes of the community, and to be responsible for any outbreak of epidemic and the measures connected with its prompt suppression. In close correlation with him would be a Board of Experts of all kinds, sanitary, medical, staticians, analysts, clinicians, veterinary surgeons, in short a close co-ordination of all the factors of science making towards the maintenance of public health. It is extremely probable that the establishment of such a system at the outset would, as the Insurance Act has done, reveal an enormous amount of immediate remedial work. Such an expenditure would but demonstrate the relative economy of prevention. Its advocacy is no mere Utopianism. In the Army such a scheme is in actual working, the only necessity is to arouse a quickened consciousness of obligation in the minds of our legislators.

Readers of Samuel Butler will recall how the Erewhonian scheme of ethics countenanced any transgression against public morality as a lamentable misfortune, calling for the speedy intervention of a "straightener," whose active measures soon brought the offender back to moral health. Thus, for example, a bad case of embezzlement resulted in a drastic treatment for the unfortunate sufferer who received the sympathetic condolences of all his friends. To suffer, however, from phthisis or some such malady was regarded by them as so criminal a thing that the patient was put to all sorts of awkward straits to conceal it, and an amusing episode is that in which a young lady of good family, a victim to dyspepsia, tries to condone the offence by attributing it to an over-indulgence in alcohol! Such a reversal of accepted practice would doubtless involve as much hardship as our criminal legislature of to-day; nevertheless, Butler's message is a true one. Until we regard health as a positive state, and not merely absence from specific illness, and visit ill-health, if not with drastic penalties upon the sufferer, at least with a rigid inquiry as to the reasons of its non-prevention, we shall make but little progress upon the road which the energy and devotion of modern scientific workers have opened up to us.

G. H. F. G.

Report by Dr. Waldo.

Dr. Waldo, His Majesty's Coroner for the City and Southwark, in his Annual Return for 1915 to the Corporation of the City of London, reports that he has inquired into 696 deaths and non-fatal fires. As regards traffic fatalities, he held inquests on 63 such deaths—the highest number since the introduction of motors yet recorded by him. Dr. Waldo points out that the marked increase in these deaths, throughout London, synchronises with the darkening of the streets and bridges dating from the first Order, made on the 1st October, 1914. He adds: "There can, I think, be little, if any, doubt that the main factor in the cause of the increased number of traffic fatalities is due to the want of light." As regards prevention, the most pressing needs emphasised are:—1. More street refuges—including such in broad streets along which tramcars run. 2. More police, stationed especially at traffic crossing points. 3. More lifeguards or fenders—at least in the shape of sideguards for hind wheels—for all heavy motors. Dr. Waldo, on the question of treasure trove, reminds the Corporation that he called their attention, in his return for 1914, to the alleged discovery in the city of a hoard of Tudor ornaments, made of gold, and of jewellery set with precious stones of considerable value. Such treasure, he says, unearthed in the city, or in the ancient borough of Southwark, belongs by Royal Charter to the Lord Mayor, Commonalty, and citizens of London, and, apparently,

"the trove has been secured by the Treasury by a secret arrangement with a certain person or persons, and no reference made to the coroner of the district in which it was found with the view of an inquest being held in accordance with ancient law and custom." Fifty-two of the ornaments were at present at the London Museum, St. James's, and the remainder he (the Coroner) had seen on view at the British Museum, Bloomsbury, with the legend attached that the jewellery had been "found in London," and had been given by the Right Hon. Lewis Harcourt, Secretary of State for the Colonies, 1914. Dr. Waldo explains that, unfortunately, he is unable to hold an inquest, since the trove lies outside his district and jurisdiction, "from whence it has undoubtedly been removed."

With reference to the difficulty poor people experience in obtaining artificial teeth, and the dangers to health and life therefrom. Dr. Waldo gives various examples in which death in toothless persons, or persons with septic stumps only, was due to want of masticatory powers causing debility, semi-starvation, and suffocation. The Coroner relates how "A report of one of these inquests, held by him, appearing in the Press, was read by Mr. Edwin Tate, who most generously presented £5,000 to St. Bartholomew's Hospital with which to start a trust fund to provide poor and deserving out-patients with artificial teeth. Other hospitals—*including Guy's*—at present unendowed, would doubtless be glad of a similar gift at the hands of some other good Samaritan."

With respect fo fires, Dr. Waldo again suggests the advisability of an extension of the special City Fire Inquests Act to his jurisdiction in Southwark, and, indeed, to the country at large, as recommended in the report of the Departmental Committee in 1909. He adds: "At no time is there greater need for full and careful judicial investigation into the origin of fires than at present, with a big war still waging." "The fact," he says, "that a public inquiry may be held has a deterrent effect on incendiarism, and, if an incendiary fire takes place, an inquest provides additional machinery for detecting and punishing crime."

Change of Address.

B. G. Tasker, L.D.S., from Colebrook, 12, Goldstone Villas, Hove, Brighton, to Inverkeg Chase, Court Gardens, Enfield, Middlesex.

Private D. Semale-Adams, South African General Hospital, Mont Dore, Bournemouth.

Herbert T. Berncastle, 1st Battalion Bedfordshire Regiment, British Expeditionary Force, France.

(The Editor will be very glad to receive a post card with notes of any change of address.)

In Northern Rhodesia.

Every available medical officer in this service is either serving with the troops on our Northern border or at home. Those that cannot be spared have extra work to do here, and have to content themselves with that and donning kharki in the Northern Rhodesia Rifles as their share of the War. I am leader of the local unit and have just received my stripes.

Perhaps some recent experiences might prove of interest, as the Editor begs for contributions. It is as I write the witching hour of midnight, and I am waiting for a train that may arrive at any time between now and daybreak, so as I dare not risk going to bed, I am inspired to write to the Gazette.

Last Saturday I was called at midnight, by a ganger who informed me that his wife was having a miscarriage, and asked me to come with him at once. He had his trolley pushed by natives. I donned amongst other things a kharki flannel shirt, a thick Harris tweed coat, and foolishly imagined that I should be warm enough for a summer night. It had been raining and a sudden drop in the temperature resulted. The case was 33 miles away, and we arrived there soon after dawn, after a very miserable night, during which I suffered intensely from the cold. The natives four in number which pushed the trolley, did the whole journey 66 miles there and back in just under 12 hours. I saw the patient, prescribed an enema, and all was well. At this siding frantic messages reached me from a place 100 miles away informing me that two confinements had taken place there and I was wanted urgently. A train left at 11.30 that night, but the only accommodation was the guards van. I spent night number two in this train, again miserably cold, while there was an added pest in the numerous mosquitoes, who soon put an end to any attempt to such sleep as an upright position on a wooden seat might have allowed.

At about 3.30 a.m. the drivers invited me into their caboose, and filled me up with hot coffee which saved my life. I arrived at the place the stork had visited about thirty hours after the event. The local vet. had come to the rescue in one of the cases, and had dealt with cord by cutting it off flush with the abdominal wall, not having attempted to ligature it. There was no hæmorrhage. There were still cases farther on, so I journeyed on, and reached a Dutchman's cottage about 10 a.m. Here an infant was very bad with malaria. It was a baby girl eight months old. The mother told me for weeks past it had had great pain on passing water. I had rather discredited this, putting it down to a Dutch yarn akin to the earache from which all Dutch babies suffer. I happened on this occasion to see it pass water, and it certainly did appear to suffer pain. I had given it pot cit without result, so I now added a little belladonna with splendid results. This case confirmed one

of my most useful axioms, "You cannot afford to neglect what a mother tells you about her baby." I travelled back five miles to a government station where they gave breakfast at midday, and then back 21 miles to the confinement cases. En route the ganger bagged a guinea fowl which foolishly crossed the line in front of us, and wounded a dinka, which however we failed to secure, and I missed a couple of pheasants rather severely. I changed trollies en route. and the second ganger had no guns so of course a cheetah ran for a hundred yards in front of us, then stopped and straafed us for quite a minute and finally disappeared in the long grass.

A nurse who had now arrived for one of the confinement cases, informed me that the patient had piles. On examination there was a prolapse of the anus the size of an orange. In the bowel wall there were some hard lumps the size of an hazel nut intensely painful. These were not sevsile, and I took them for thrombosed veins. I failed to reduce this prolapse. The other lady was Dutch. I was informed by the local ladies that by their united efforts they had persuaded the old fraauw in attendance to give the patient a wash after the event. What she was like before the wash heaven only knows, she out-boro'ed the Boro' when I saw her. The infant failing to take the breast was put on a diet of coffee for about a week.

A week later I visited the prolapse case—nine days after the confinement. The mass was now much smaller as the result of hot fomentations, and I replaced it easily. Result: the patient nearly went mad with pain. There was no doubt as to the agonising nature of the pain. The patient for over three hours was continually moaning and screaming out, she was sweating and retching, and had a very distressing expression of fear and pain. I examined. The bowel appeared to have been replaced quite normally, but the hard masses mentioned before could be felt, and were compressed by the sphincter. I ordered hot fomentations, gave ½ gr. opium, repeated it in half-an-hour, and again in another half-hour with no relief at all. I spent a very cheery three hours with the husband, listening to his wife's groans. I had made up my mind to give chloroform and forcibly dilate the sphincter, when the bowel prolapsed again, the pain ceased immediately and the patient fell asleep. The previous history was as follows:—A lump came down at previous confinement 6 years before, stayed down 6 days, and then went back of its own accord. At her last confinement, 2½ years ago, a lump come down, and was immediately replaced by her doctor. During present pregnancy suffered from bleeding piles, losing a lot of blood. These piles protruded from time to time and went back. A mass was protruding for a month previous to parturition. This the patient thought was piles. Comments on this case would be welcome.

This week, on Wednesday, I rode 22 miles, on Thursday 18. The patient was a small child with malaria. The mother informed me her baby was not well, It seemed particularly cheery, but remembering my axiom I took its temperature. It was 100, and the same night the child was very ill with malaria. The mother had fifteen children. By the way, is it a fact that all babies are born with blue eyes? A nurse fresh from the Rotunda was greatly amused at my ignorance of this fact. My Dutch mother of 15 laughed the idea to scorn, and declared three of her children were born with brown eyes.

To-day, Friday, I was just starting on 35 miles byke ride, when I received another message asking me to go to a farm 11 miles in this district. I got back from the farm at sundown, and am now waiting for the train to take me to the former case.

The roads at this time of the year are in a terrible state to travel over, consisting most of thick black slippery mud, trying both to horse and rider, so the above few days' work is more wearing than would appear from distances travelled.

P. H. WARD.

Lusaka, N. Rhodesia.
January 21st, 1916.

Appointments.

Royal Naval Volunteer Reserve.

A. H. FitzGerald to be Temporary Lieutenant.

Royal Army Medical Corps.

The following appointments have been made:—

Temporary Lieutenants H. W. Fox, A. Frazer, E. S. Hall to be Temporary Captains.

To be Temporary Lieutenants:—J. Young, C. R. Howard.

South African Medical Corps:—Lieut. H. R. Mullins to be Temporary Captain.

Temporary Lieutenant R. C. Matson to be temporary Captain.

R.A.M.C. (Territorial)

Western General Hospital: Lieut. R. T. Jones to be Captain.

London General Hospital: Major (Temporary Colonel, A.M.S.), A. H. Tubby to be Lieut.-Colonel, and remain seconded.

Capt. F. F. Burghard to be Major.

London (City of London) General Hospital: Lieut. R. J. W. A. Cushing to be Captain.

West Lancashire Division Sanitary Section: Lieut. A. Reid from London Sanitary Company, to be Lieutenant.

London (City of London) Field Ambulance: Lieut. D. H. Platt to be Captain.

Welsh Border Mounted Brigade Field Ambulance: Lieut. W. Morgan resigns his commission.

Reading War Hospital No. 5: Lieut. E. F. Clowes, R.A.M.C., to be Officer in Charge.

The British South Africa Company.

Northern Rhodesia Volunteer Force:—Dr. P. H. Ward to be Second Lieutenant.

School Children in Ear and Throat Department.

By W. M. MOLLISON.

It may be of interest to your readers to hear of the efforts made to improve the attendance and thus the treatment of school children in the Special Departments. For three or four years there has been a good deal of work done in the Special Out-Patient Departments (Ear and Throat and Eye) by ladies entitled Assistant Organisers of Care Committees. The following explains the existence of these ladies—

The L.C.C. doctors or nurses inspect school children; those needing advice and treatment are instructed (or rather their parents are instructed) to attend at some hospital or treatment centre. In connection with each school or group of schools are Care Committees whose business it is to see that the children do attend at the hospital or treatment centre. These Care Committees appoint the Assistant Organisers who attend in the Out-Patient Department and form the link between the hospital Out-Patient Department and the Care Committees, and thus the schools.

In the Ear and Throat Department the A.O. takes brief notes of every school child, the diagnosis and treatment advised; she explains to the child exactly what to do, and if need be writes to the Committee about the child. For instance, if the child fails to attend, either for treatment or operation, she reports the matter and the parent receives a letter urging or commanding her to take the child to the hospital.

From the point of view of the surgeon and the clinical assistant the help thus given is most valuable and time saving, and it is satisfactory to feel that there is a reasonable chance of seeing the patients a second time, and of treatment being carried out; thus, too, results of treatment may be judged and improved. It is this last point which is of considerable interest; every year in the Ear and Throat Department about 2,000 children are seen; many of these are under or over school age. The A.O. only tackles the school children.

The question of the amount of good being done among this mass of children is a very difficult one; the surgeon gains only an impression, there is not time to follow up all the cases and collect statistics, but now, through the A.O., there is a means of obtaining some figures which are of interest.

The lady that worked in the Department in 1914, and the present one who has been there since the beginning of 1915, have both most kindly worked out the figures as far as they could. This has entailed much work on their part, and the incomplete results indicate the very great difficulties met with in dealing with the out-patient class. The investigation deals only with those cases operated upon for the removal of tonsils and adenoids, and, as will be seen, the cases were divided into groups, each group including cases dealing with some prominent symptom—(1) rhinitis and nasal obstruction; (2) otorrhœa; (3) deafness; (4) sore throats.

It is obvious that these figures cannot be accurate on account of the great difficulty met with in persuading the children to attend after operation. The numbers under the heading "presumed good result" are certainly too high; in consequence, the percentage of good results are highly optimistic. Actually seeing figures serves to focus attention on the shortcomings of treatment, and sets a standard to be improved upon and surpassed.

GENERAL RESULTS OF OPERATIONS FOR REMOVAL OF TONSILS AND ADENOIDS.

	1914		1915		
1. Number of operations ...	366	...	382		
2. Number discharged as well or reported well	136 = 37·1%	...	147 = 38%	77%	
3. Number not discharged, but possibly well	Figures not given.		149 = 39%		
4. Number who failed to attend, *i.e.*, neglect			63 = 16%		
5. Current cases			23 = 6·0%		
Three cases of pneumonia following operation were reported; all recovered.			No case of pneumonia occurred, but four cases of septic absorption were admitted; all recovered.		

RESULTS OF OPERATIONS ON THE INDIVIDUAL GROUPS

	Rhinitis and Nasal Obstruction.			Throat.			Deaf.			Otorrhœa.	
	1914	1915		1914	1915		1914	1915		1914	1915
Number operated upon	26	69		—	114		37	66		124	126
Good result	16	25	76%	—	51	86%	17	18	72%	35	50
Presumed good result	1	28	= 65%	—	48		—	30		—	43
Failed to attend	6	14		—	14		—	8		75*	25
Still attending	3	2		—	1		—	8		14	8
Percentage successful results ...	65	76		No figures	86		45·9	72		27·9	73

*This figure certainly does not indicate successful results, but mixed success and failure no doubt.

The College—Tel. No. 10.

A little round-faced, expressionless clock away above me has steadily made up its mind that the world outside would say it was 3 a.m. I cannot see it, for all is darkness, silence, and warmth around me; when suddenly I notice the hum of motor without. A piercing voice cries, "Gates on the left!" The hum draws nearer. "Gates on the left, you owl! Here, left." A wheezing and sliding, then only a steady throbbing continues below my window. Footsteps without; there is a chink of coins. "You've got all the change." "Not at all." "Mine as well as your own." "Not at all." "Get along; this my show; you try to find the bell, and ring it. How much does it say, Archibald? Right." Clink, bang, and the hum recommencing fades slowly in the distance.

Somewhere in the obscurity I hear a bell ring in a jerky, undecided way; then silence. "Go on, lean your head on it, old man"; and the bell rings more vigorously. Below me someone stirs, yawns audibly, turning on the light, and after a vigorous shake down, disappears, post haste, to admit the belated wanderers. Through the little gate they come singly, and a little suddenly as though propelled by unseen forces. To me through my window they are just a succession of flashes in black and white, crowned by a shimmer of silk. Someone greets them from within, "Hullo, caught you again! Where have *you* been?" Then comes a suppressed whispering, but, alas, I cannot hear. The laughter hardly so well suppressed, and I fear for the nocturnal comfort of our austere neighbour in the house across the way. Then feet patter and slide away in the distance. "Good night." "Bye, bye. You're not going round, are you, Keen?" "No, rather not; all done for me, old man." "Same here. So long." "So long."

The door of my small house closes, the reign of warmth, darkness, and measured breathing is resumed, and for a while even I indulge in a little well-deserved slumber. Then slowly my old restlessness returns; I feel impelled to emit my insistent buzz, with ever increasing vigor until the light again floods round me, and I am answered, "Hullo, hullo!" In feverish haste I reply, "Will you tell Mr. Keen he's wanted in Marrison ward? No. 13 has gone to sleep." "Urgent, did you say?" "Urgent, yes." "Marrison No. 13?" "Yes, Marrison."

Click and my erstwhile companion departs with an air of stately determination. In silence I picture the rush of night air on the recumbent limbs, the blinking eyes, the curse! Oh, the cruel hardships of a medical life. Why must I always cause such pain, yet can never express my sympathy? F. A. K.

F. A. K.

GUY'S HOSPITAL GAZETTE.

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Passim.

WE offer an apology for the smallness of this issue of the GAZETTE, the coincidence of Easter with the normal date of publication having made its early appearance and corresponding brevity unavoidable.

IN this season, which seeming years ago gave such welcome respite after the days of darkness and gloom and so well relieved the impatience for the charm and beauty of summer, we at home find ourselves in a curiously uncertain atmosphere. So much news do we hear both from the public press and the mysterious and exclusive channels of rumour, that we often may for a moment be tempted to indulge in thought and speculation as to the next turn in the course of our history. Yet after such a brief excursion we remember that even the highest seem unceasingly to contradict, criticise and condemn all and everything within reach. Always the cry is for unison, yet on every hand there seems ever-increasing discord. From month to month, even from day to day, our policy appears to vary, sometimes in so dramatic a manner that it brings a feeling more of exasperation than of interest. And is this oscillation due to actual happenings, our perception of them, and our corresponding elation or dismay, or is it due to the subtle but distressingly powerful influence of an ambitious and unscrupulous press?

If all were given even only one twentieth part of the information deluged upon us, and knew that there was no possible doubt as to truth and origin, we believe that there would be no cause for the repeated cry anent half-measures and the like. We believe that a man can only give of his real best when working along a definite line with definite objective, and in the present crisis, when it is all young brains and limbs that are called to make their best endeavours, we expect them to need a firm guidance which only singleness of purpose among their leaders can give. It is far beyond our scope even vaguely to suggest the exact lines these leaders should choose, but surely it is better that the Government, once having the power, should be allowed unmolested to proceed with the work in hand. Theirs is the duty to lead, the country's to follow, and seeing that only by unison will the greatest efficiency be obtained, we feel that the present day press-cultivated criticism is tending to disperse rather than realize our national hopes and ideals.

At a General Court of Governors, held on Friday, April 7th, Sir Geoffrey Cornewall, Bart., and Almeric Paget, Esq., M.P., were unanimously elected as Governors of the Corporation.

By the death recently of General Clive, a Governor of the Hospital since 1883, a vacancy had occurred on the Estates Committee, and Sir Geoffrey Cornewall, whose Estate adjoins the Property of the Hospital in Herefordshire, has been appointed to fill the vacancy. Mr. Almeric Paget has been appointed on the House Committee.

We would draw attention to a letter appearing later in this issue with regard to one of the many minor functions which have been in abeyance during the war, namely, the Guy's Hospital Ball.

We are glad to hear of the excellent way in which the Committee have disposed of their surplus funds.

Addressed to the House Surgeon, Guy's Hospital, comes the following letter from France, dated April 1st!—

"Sir,

Will you kindly settle the following question for me, as a wager is at stake?:—

What is the average weight of an Adult Brain?"

Thanking you in anticipation,

Yours very sincerely,

Corporal Butterworth.

N.B.—Sir, will you kindly sign your name and hospital at the foot of the answer?"

Can this letter be as guileless as it seems? We wonder. At any rate we feel assured that the Residents who kindly forwarded the information needed were in no sense at a loss as to the answer.

May we once again call attention to the presentation to Mr. John Morley on his retirement after 35 years' service. The following have consented to receive contributions from students limited to 5s.:—Messrs. N. E. Kendall, F. Caldecott, C. L. Curle, L. S. Debenham and P. Green.

It is hoped that the O.P.O.s enjoyed their recent board meeting and joy ride in the surgery lift. We feel that for invulnerable seclusion the idea has seldom been surpassed.

We wonder how much of public sympathy and support was vouchsafed to the gentleman who recently in Parliament vigorously criticised the action of the authorities in declining to employ bone-setters in the early or late treatment of our disabled soldiers. According to medical administration the suggestion was completely impossible, and will remain so as long as the "registered medical practitioner" is recognised. For those who search for opportunities for indignation this seems particularly ill-chosen ground. However sincerely the gentleman in question may believe himself cured by a bone-setter, we feel this is hardly sufficient argument to cause a general set-to npon British Soldiers, and the heaping on already aching Government shoulders of responsibility of discrimination amongst the army of quacks of every description which would be immediately at their doors.

It is rumoured there is a suggestion in America that owing to the need of English-speaking medical men vacancies in our own and Colonial services may shortly be open to our cousins from U.S.A. We have seen no opinions expressed. It would be interesting to hear some.

Change of Address.

Temporary Captain R. C. Matson, R.A.M.C., from 71st Field Ambulance, to attached 8th Battalion, The Yorkshire Regiment, B.E.F.

N. S. Carruthers, M.R.C.S., L.R.C.P., from The Firs, Reedham, Norfolk, to Oakley House, Acle, Norfolk. *Telephone:* Acle 6.

A. Hammond-Smith, L.D.S., from 219, King's Road, to 202, King's Road, Reading. *Telephone:* 897 Reading.

(The Editor will be very glad to receive a post card with notes of any change of address.)

Correspondence.

To the Editor of Guy's Hospital Gazette.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

Dear Sir,—I notice that a list of Guy's men on service is being compiled by the Wills Librarian. I do not think the names of two Guy's men of long ago have yet been reported: one is Major W. E. Kelbe, who left the hospital in 1889, the other is myself. Kelbe is now Second in Command of the 6th South African Field Ambulance in German East Africa, and will, I hope, win further distinction. He went through the Anglo-Boer war, in which he was severely wounded while attending wounded on the field. The other is myself, who left Guy's in 1890. I am now a Colonel and Acting Director of Medical Services for the Union of South Africa. I was through the whole of the G.S.W.A. Campaign, and was honoured by being twice mentioned in despatches. I only put this forward to show that Guy's sons try to make themselves worthy of the School at which they were educated.

General Smuts had made a good beginning in German East and we South Africans look forward to being, to some extent, the means of driving the remaining Huns out of the Sub-Continent and win fresh laurels for the arms of the Empire and the Union.—I am, Yours faithfully, G. H. KNAPP, Col.
Acting Director of Medical Services,
Pretoria Club, Union Defence Forces.
Pretoria,
15*th March*, 1916.

Sir,— Dr. Fawcett's clinical lecture on paratyphoid fever in the Gazette of March 11th covered the ground so well that I should not have troubled you with this letter if it were not for the fact that I thought you might like to hear some conclusions drawn from the observation of a large number of cases seen during the last five months at Lemnos and Salonica.

I should say that paratyphoid fever is clinically recognisable by six characteristic features, most of which were referred to by Dr. Fawcett: (1) Sudden onset; (2) a curious course, marked by the toxic symptoms reaching their fullest development within the first week, after which improvement rapidly occurs, even if the temperature remains high for another two or three weeks; (3) spikey character of the temperature chart when taken twice a day; (4) slow pulse compared with the temperature, but at the onset the pulse may be fast, and in about 10 per cent. of cases marked dilatation of the heart with tachycardia is present and may subsequently lead to the development of a "soldier's heart" if the patient returns to duty too soon; (5) spots which are often larger, more irregular in shape, more raised, and brighter red than in typhoid fever; they are often grouped together and are occasionally very profuse; and (6) a spleen which is palpable in 60 per cent. of cases and enlarged to percussion in *all* cases; it is often quite characteristic in being remarkably hard—more like a malarial than a typhoid spleen; it is tender in the early stages, and tenderness under the left costal margin is well-marked even when the spleen is not palpable; the pain may be so severe that pleurisy is simulated; the enlargement is often felt curiously far forward under the left rectus even when it is not felt further to the left; the hard spleen is often palpable after the temperature falls to normal.

I do not think the tongue at all characteristic. The disease is so mild that we habitually give biscuits and often bread and butter, with the result that the tongue is almost always moist and clean; paratitis has never occurred and other septic complications observed in France have been very rare. Paratyphoid A *is much more common than B out here; it is sometimes* very mild, lasting less than a week, but is often quite severe, especially in the frequent cases in which it is complicated by bronchopneumonia. So common, indeed, is the latter compared with ordinary pneumococcal infections that the possibility of paratyphoid has to be considered in every case of pneumonia. The mortality is not more than one per cent. The appearances varied greatly in the few post-mortems I have seen; in one case of paratyphoid A there was an acute colitis with no ulceration, whilst in another the ulceration involved the whole colon and even the rectum as well as the last three feet of the ileum.

Typhoid fever is rare and almost always "modified" by previous inoculation, so that it is an even milder disease than paratyphoid fever, and entirely unlike typhoid fever as seen in England. I have seen very few unmodified cases—all in uninoculated soldiers; one, in which death occurred, was hæmorrhagic in type, the body being entirely covered with huge purpuric patches, and submucous intestinal hæmorrhages were found at the post-mortem, though no hæmorrhage had occurred before death.—Yours,
Salonica, A. F. H.
2*nd April*, 1916.

P.S.—I performed a post-mortem on a fatal case of paratyphoid fever A to-day, and the conditions found were, I think, sufficiently interesting to be recorded. The cause of death was suppurative nephritis; both kidneys were much enlarged, deeply congested,

and showed numerous hæmorrhages under the capsule, which slipped easily. A large number of small necrotic areas and minute abscesses were present, especially just under the capsule. There was only slight inflammation of the pelvis of the kidneys, but well-marked cystitis. Death occurred at the end of the fourth week, and no active ulcers were found in the intestines. The last few inches of the ileum showed extensive scarring, due to recently healed ulcers, small, deeply-pigmented area of mucous membrane projecting like papillomata from a smooth depressed surface, representing the healed ulcers, which must have involved a large proportion of the area. The mucous membrane of the large intestine was congested, especially in the descending colon, but no signs of recent or old ulceration could be found.

3rd April, 1916. A. F. H.

Medical School,
Guy's Hospital, S.E.
11th April, 1916.

Dear Mr. Editor,

I shall be much obliged if you will arrange to publish the accounts of Guy's Hospital Ball in accordance with the appended audited statement.

It might be of interest if you would mention, as an introduction to the statement that a small balance was retained from the last Ball held in November, 1913, to provide for the purpose of initiating arrangements for a subsequent Ball. As, however, there is little likelihood of such an event occurring in the near future, it has been decided to give this balance to charity, and accordingly the account was closed by paying the sum of £3 19s. 11d. to the Guy's Hospital Maternity Samaritan Fund on the 31st March.—Yours faithfully,

L. BROMLEY,
Hon. Treasurer, Guy's Hospital Ball.

GUY'S HOSPITAL BALL.

1913.	Receipts.	£	s.	d.
Nov.	To Balance brought forward from last account	3	18	8
1916.				
Mar. 31.	To allowance from Bankers for unused cheques	0	1	3
		£3	19	11

1916.	Payments.	£	s.	d.
Mar. 31.	By Donation to Guy's Hospital Maternity Samaritan Fund ...	3	19	11
		£3	19	11

Audited and found correct,
(Signed) W. J. CURRY,
10th April, 1916. Corporate Accountant.

Three Cases of Paroxysmal Hæmoglobinur a in Soldiers.

By DESMOND MacMANUS, M.R.C.S., L.R.C.P.,
Captain R.A.M.C. (Temp.); Attached Inns of Court Officers' Training Corps, Berkhamsted.

In view of the comparative rarity of this condition the following cases possess considerable interest. All three men were in the early stages of their military training and paraded sick owing to discoloration of the urine, which, coupled with a feeling of great exhaustion, caused them considerable alarm.

Case 1.—Private H., aged 18. No history of venereal disease. Woke up one morning after night operations feeling very weak and shivery, and noticed that his urine was red in colour. His temperature was 100·8°; no physical signs could be detected, except that the spleen was just palpable. The urine was dark brown and contained heavy deposits; it showed the presence of albumin, and gave a positive reaction to the guaiacum test. On microscopic examination a few red corpuscles, a quantity of amorphous pigment, and some bladder epithelium were seen. Spectroscope examination showed the absorption bands typical of methæmoglobin. The patient was put to bed with hot-water bottles and given warm drinks. After twenty-four hours the urine was clear, and he felt quite well, though weak. He was given an iron and arsenic tonic, and returned to special duty in a few days. He had no recurrenee while under my observation.

Case 2.—Private S., aged 32, had suffered from malaria in 1912 while in the tropics. He had led a sedentary life until enlistment. His attack started suddenly with severe lumbar pains after exposure to cold and wet. On examination he had a temperature of 102·2°, which, however, quickly fell after rest in bed. There were no abnormal physical signs; the spleen was impalpable. His urine, which was examined both microscopically and spectroscopically, presented the same characteristics as in the preceding case, differing only in specific gravity. A blood examination showed a leucocytosis of 9,800. This man continued to pass blood-stained urine for forty-eight hours. He was given similar treatment, and was soon back at work. He is now in Mesopotamia, and when I last heard from him had had no recurrence.

Case 3.—Private J., aged 28, had had a similar attack previously in civilian life. On this occasion the onset was sudden, accompanied with great exhaustion. His temperature was 102°, and the spleen just palpable. After being put to bed he complained of an intense "itchiness" all over. The urine had the same physical, microscopic, and spectroscopic characteristics as previously described, and he also had a leucocytosis. He recovered from this attack in twenty-four hours, but had a relapse about six weeks later. He was eventually put to clerical work and has not suffered since.

In all these three cases the exciting cause was apparent exposure to cold coupled with considerable bodily exertion. In none was there any admission of syphilitic taint. The Wassermann reaction was not done in any of the cases. On examining the cases admitted into Guy's Hospital during the last few years, I find that in the last three the Wassermann test was performed, and was positive in all of them. Malaria is cited by some authorities as an etiological factor, and Case 2 had suffered from this disease. It is interesting to note that in none of these cases was the initial temperature under 100°, and that in none of them did the urine clear up under twenty-four hours. This apparent severity was, no doubt, due to the considerable exposure and exertion undergone.

The most generally accepted theory of causation is that a hæmolysin exists in the blood of these cases, the amboceptor of which will only unite with the red blood cells in the presence of the complement, and at a low temperature. This low temperature was present in all the cases under consideration. It seems to me that these men, all of whom had lived sedentary lives prior to enlistment, when thrust rapidly into the full stress of military life, had given way at the weakest point, which in them happened to be in the blood. I am convinced that were a more gradual system of early training recruits more generally adopted many fewer would succumb and be invalided out of the service. In Cases 1 and 2 the patients were put back and allowed only the minimum of physical effort, which was increased by degrees with the view of more thoroughly hardening them and enabling them to withstand both cold and exposure. So far, after nearly a year in both cases, neither has to my knowledge suffered a relapse.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Appointments.

Civil.

N. S. Carruthers, M.R.C.S., L.R.C.P., Oakley House, Acle, Norfolk, District Medical Officer and Public Vaccinator, Blofield District Council.

Royal Army Medical Corps.

The following appointments have been notified:—

Temporary Lieutenants to be Temporary Captains:—H. H. Elliot, H. H. Davis, O. Bowen.

To be Temporary Lieutenants:—A. Walker, H. Tipping.

Temporary Captain C. H. Mills relinquishes his commission.

Canadian Army Medical Corps:—Temporary Lieut. F. W. Lee relinquishes his commission.

R.A.M.C. (Territorial).

Scottish Horse Mounted Brigade Field Ambulance:—Major H. Richardson to be Temporary Lieut.-Colonel whilst in command of a Field Ambulance.

North Midland Field Ambulance:—Lieut. T. E. A. Carr to be Captain.

Southern General Hospital:—Captains E. C. Bevers and H. E. Counsell,

Papers by Guy's Men.

Capt. W. Sampson Handley, M.S., F.R.C.S., R.A.M.C.: A method of treating general peritonitis with obstruction, and its application in military surgery.—*The B.M.J.*, April 8th, 1916.

E. W. Ainley Walker, M.A., M.D. Oxon, in collaboration with Georges Dreyer, M.A. Oxon., M.D. Copenhagen, and Alex. G. Gibson, M.D. Oxon., F.R.C.P. Lond.: Further remarks on agglutination tests in inoculated persons, and the influence of febrile conditions on inoculation agglutinins.—*The Lancet*, April 8th, 1916.

R. P. Rowlands, M.S., F.R.C.S.: Time in Surgery.—*The B.M.J.*, April 16th, 1916.

Capt. D. M. MacManus, M.R.C.S., L.R.C.P.: Three cases of paroxysmal hæmoglobinuria in soldiers.—*Ibid.*

Capt. C. L. Chapman, R.A.M.C.: Case of bullet wound of skull.—*The Medical Journal of Australia*, February 26th, 1916.

Temporary Surgeon Hildred B. Carlill, M.A., M.D. Cantab., M.R.C.P. Lond., R.N.: The diagnostic importance of the ankle-jerk.—*Journal of the Royal Naval Medical Service.*—April, 1916.

Surgeon A. M. Henry, R.N.: An autopsy in acute bacillary dysentery.—*Ibid.*

A Method of Treating General Peritonitis with Obstruction,

And its application in Military Surgery.

By W. SAMPSON HANDLEY, M.S., F.R.C.S.,
Captain R.A.M.C. (T.).
(With acknowledgments to the *B.M.J.*)

My interest in the subject of obstruction secondary to peritonitis dates back for ten years. During this period I have been collecting cases in which, as the result of peritonitis confined to the pelvis, obstruction has supervened. My conclusions were presented in a Hunterian Lecture last year. I showed that the guts below the horizontal level of the symphysis were paralysed, while the bowels above, though distended, retained their contractile power. As the pelvis contains both a length of large and a length of small intestine, there are two obstructions to be dealt with, and the name "ileus duplex" was suggested for the condition.[1]

The success of the treatment I adopted in cases of ileus duplex led me to attack on the same lines the more difficult problem of paralytic obstruction in cases of general peritonitis.

It must here be remarked that not all cases of general peritonitis go on to the stage of obstruction. This is especially the case in children, and I have operated upon a boy of 12 with absolutely universal peritonitis extending up to the diaphragm in whom no sign of obstruction was present. Recovery followed free drainage of the peritoneal cavity. Furthermore, in the early stages of general peritonitis peritoneal drainage is often successful in arresting the spread of the peritonitis and in preventing the onset of obstruction. There are, too, numerous cases of mild paresis of the bowel in peritonitis which can be successfully treated by subcutaneous injections of eserine, by turpentine or ammonia enemata, or by purgatives. This paper deals exclusively with cases in which the accepted modes of treatment have failed to avert or relieve paralytic obstruction of the bowels.

If there is a condition in surgery which is stamped with the word hopeless, it is that stage of a general peritonitis where, in spite of pelvic drainage, cessation of the passage of flatus and persistent foul vomit indicate that complete obstruction has supervened. The rigid abdominal muscles have been forced to yield by the pressure of fluid poured out into the paralysed intestine, and the abdomen is uniformly and tightly distended like a drum. The pulse becomes running, the extremities cold, and the patient, measuring his condition by the abnormal clearness of his faculties, only within a few hours of the end realizes with a horrible certainty that he is in the inexorable grasp of death.

This would be accepted as a true clinical picture of the later stages of general peritonitis. But in abdominal surgery typical "clinical pictures" are of pathological interest only. They imply that the surgeon's chance has gone.

Is it inevitable that cases of general peritonitis should reach the condition thus depicted? There is a preceding stage in which the obstruction is complete, but the pulse is still relatively good, and the vomit has not become offensive. The abdomen is generally distended, but it is absolutely rigid only below the umbilicus. The upper half of both recti is softer than the lower half, and above the umbilicus slight respiratory excursions of the abdomen can still be seen.

This is a stage of general peritonitis which is not recognised in the textbooks, but is known to all surgeons of much clinical experience. It is the stage of the clinical sketch, not of the clinical picture; the stage of deadly struggle, not yet of decisive defeat.

Is the problem presented by such cases really hopeless of solution? By the present methods of surgery it certainly is. There are, however, certain indications that it may not prove insoluble. Let me tabulate these hopeful indications:

1. General peritonitis is rarely universal.
2. General peritonitis usually begins at the lower limit of the peritoneal cavity and spreads gradually upwards.
3. The persistent vomiting indicates that the stomach and upper bowel retain their contractile power to a late stage.

General Peritonitis rarely Universal

What is meant by the term "general peritonitis"? The term is loosely used. It is quite certain—and here I speak from my own experience in the operating theatre—that in cases presenting the clinical features of general peritonitis universal peritonitis is rarely found. Any widespread peritonitis unlimited by adhesions is included under the clinical term "general peritonitis." If as a rule the peritonitis involved the upper part of the abdomen, it would avail little that its distribution is rarely universal, for in these circumstances the treatment I am about to suggest would be impossible. Fortunately, however, general peritonitis, whatever the point at which the infection reaches

the peritoneal cavity, usually begins in the pelvis and spreads upwards.

In cases of general peritonitis due to appendicitis the infection of the peritoneum invariably starts in the pelvis. It is the rule, even in cases where the source of infection—for example, a gastric ulcer—is in the upper part of the abdomen, that an unlimited peritonitis is at its maximum in the pelvic region, and that it spreads from below upwards through the abdomen. This of course depends upon the fact that gravity carries most of the irritating material down to the lowest point of the abdominal cavity. Moreover, if the rupture is on the anterior wall of the stomach, the great omentum shields the small intestine. If the rupture is on the posterior wall, the contents of the stomach reach the pelvis by way of the right kidney pouch, and do not much affect the small intestine. But there are exceptions. If there is very extensive fouling of the peritoneum, as by the escape of a large quantity of stomach contents through a perforation, or by multiple wounds of the intestine, a true universal peritonitis may be set up. Wallace records death from peritoneal inflammation within twenty-four or thirty-six hours of a gunshot wound. Such cases are, however, exceptional, and it may be stated, broadly speaking, that a so-called general peritonitis is an unlimited peritonitis commencing in the pelvis and spreading gradually upwards, so as to involve a larger and larger area of the peritoneal cavity. This statement is based upon inspection of the abdominal cavity during life in a large number of cases. I am convinced that in the vast majority of cases of general peritonitis a cautious investigation of the upper abdomen would show it to be uninvaded. Among some hundreds of cases of appendicitis with peritonitis I only recollect a single one in which a true universal peritonitis, affecting every district of the peritoneum, was present.

Persistence of Contractile Power in the Stomach and Upper Bowel.

It may seem paradoxical to include the symptom of persistent vomiting among the hopeful indications. There is, of course, a last stage where the vomiting is the mere mechanical overflow along the œsophagus from the over-distended stomach and intestines, and is similar to the gush of stomach contents from the mouth which may be produced by pressure upon the abdomen of a corpse. But in the stage prior to this the vomiting is due to active contractions of the stomach and the small intestine.

That is to say, the vomiting indicates persistence of peristaltic power in the stomach and upper intestine up to within a short period of death.

We have now reached important conclusions which will guide us in attempted treatment: (1) In general peritonitis which, in spite of drainage, has produced signs of intestinal obstruction, which has reached, that is to say, a stage now regarded as hopeless, we can still rely for a time on the functional activity of the muscle of the stomach and of the upper part of the small intestine. (2) In such cases the upper part of the abdomen, roughly speaking that part of it lying above the umbilicus, may be regarded as for some time longer free from peritonitis. In this district we may provisionally assume that surgical operations may be undertaken which postulate the power of repair, such operations, for instance, as intestinal anastomosis. The intestine in this region will be distended because of the obstruction below; it will be inflamed, if at all, only just before the approach of death.

We are now in a position to discuss the indications for operative treatment. It is fairly obvious that any treatment adopted must not involve unduly prolonged manipulation or exposure, and must not add to the shock which is already present. Any method which fails to fulfil these conditions will simply hasten death. It is for this reason partly that the emptying of the paralysed intestine by threading a tube through it has given such unsatisfactory results. Moreover, the emptied intestine still remains flaccid and powerless, and the obstruction consequently persists.

In discussing this question of treatment I must return to the subject of ileus duplex—paralytic obstruction due to pelvic peritonitis. Here, in my opinion, is to be found the key to the treatment of general peritonitis, for I found that recovery could be secured in such cases by anastomosing the suprapelvic ileum to the ascending colon, and then opening the cæcum by a cæcostomy.

The principle involved might be stated generally in the following terms:

In cases of peritonitis involving the lower part of the peritoneal cavity up to the level of the pelvic brim, when obstruction supervenes, it can be treated successfully by the improvisation of a shortened but complete alimentary canal above that level. The simplicity of this statement gives it the air of a truism, nevertheless I believe it represents a marked advance in abdominal surgery.

We have now to consider whether this principle, which has proved to be successful in cases of pelvic peritonitis, can be extended to the more difficult case in which the peritonitis is general.

In peritonitis limited to the pelvis, the intestinal paralysis affects exclusively the portions of gut contained in the pelvic basin, namely, the lower portion of the ileum, and the pelvic colon and upper portion of the rectum. In so-called general peritonitis, at the time intestinal obstruction supervenes, the line separating the inflamed and uninflamed districts of the peritoneum is, as we have seen, roughly a horizontal line drawn through the umbilicus. Below this line lies paralysed intestine, above it intestine which is still functionally active.

Thus in clinical "general peritonitis" the conditions are not dissimilar in kind from those present in ileus duplex, but the level separating the inflamed district of the peritoneum from the upper uninflamed portion is situated higher up. A much more considerable length of the small intestine is paralysed, and perhaps (*a*) the whole of the ileum may be assumed to be out of action; (*b*) the cæcum and ascending colon will be paretic or actually paralysed, so also will be (*c*) the descending colon and the pelvic colon. This stage of peritonitis may be described as the stage of hypogastric ileus. I suspect that nearly all cases of general peritonitis pass through this stage, and that in many of them the stage lasts long enough to allow of hopeful surgical treatment on the lines now to be described more in detail

The parts of the alimentary canal which are still unparalysed, and therefore available for constructing the suggested emergency alimentary canal, are the stomach, the jejunum, and probably the transverse colon, which lies on the boundary line of the inflamed district. All the rest of the intestine, small and large, is paralysed.

Is Jejunostomy a Satisfactory Treatment?

Under these conditions a jejunostomy might be tried, according to Bonney's suggestion. It would re-establish the current in the unparalysed portion of the intestine. It also might be arranged so as to cut off the reflux tide of septic material passing up to the stomach. It might thus conceivably save the patient's life, but as it would cut off the supply of fluid to the greedily thirsty mucosa of the large intestine it would probably fail, for patients with peritonitis are already starved of fluid.

(To be continued.)

Pass List.

Royal Colleges of Physicians of London and Surgeons of England.

At the First Professional Examination of the Conjoint Examining Board, held March 28th, 29th, 30th and 31st, and April 1st and 3rd, the following candidates were approved:—

Chemistry.—Maxwell Hall.

Elementary Biology.—Gerald Cecil Wootton Curson, Maxwell Hall, John Herbert, Daniel Joseph O'Meara, Norman Victor Wadsworth.

At the Second Professional Examination in Anatomy and Physics the following candidates were successful:—J. A. A. Bouic, F. K. Escritt, J. E. Fishburn, C. Gill-Carey, E. F. Kerby, H. H. Khan, C. Moffatt, A. R. Neckles, A. G. Ord, G. M. Thomas, B. M. Tonkin, J. E. de V. Van der Merwe.

PRACTICAL PHARMACY.

Part IV.

At the First Examination held early this month, the following candidates were approved:—

A. M. Ahmad, J. R. R. Brogden, G. H. Fitz-Gerald, W. H. A. Pratt, W. J. Walters, S. A. Withers.

Royal College of Surgeons of England.

At the Preliminary Science Examination in Chemistry and Physics for Licence in Dental Surgery held recently, Frank Woodford was approved.

Society of Apothecaries of London.

PRIMARY EXAMINATION.

At the Examination held recently the following candidates were successful:—

Part I.

Biology and Chemistry.—K. J. H. Davies.

Part II.

Physiology.—G. R. Aspinall, L. Lyne, H. S. Morris, G. V. Richards, A. H. Shelswell, H. W. Southgate.

Anatomy.—G. R. Aspinall, W. Kilroe, L. Lyne, H. S. Morris, G. V. Richards, A. H. Shelswell, H. W. Southgate.

Royal Army Medical Corps.

Honours.

The King has been pleased to appoint Temporary Captain James La Fayette Lauder, to be Companion of the Distinguished Service Order in recognition of his devotion to duty at the Camp of Wittenberg, Germany, during the typhoid epidemic which prevailed there from February to June, 1915.

An Idle Rhyme by an Idle Fellow.

A for appendix, I had one sans doubt,
P for the pleasure I felt when 'twas out,
P for the pain I had when "acute,"
E for excision by surgeon astute,
N for my nurses, the best ever born,
D for the dresser by whom I was shorn,
I for the idiot who wrote this bad rhyme,
X eedingly foolish such waste of his time.

(Signed) AP PENDIX AP ADAM.

Guy's Hospital.

Tables showing the Cost of Maintenance of the Electrical and Actinotherapeutic Department, the Medical Radiographic, the Surgical Radiographic, and the Photographic Departments for 1915.

ELECTRICAL AND ACTINOTHERAPEUTIC DEPARTMENT.

Year.	Number of Patients and Treatments.	Apparatus and Tubes.	Repairs and General Sundries.	Salaries.	Current.	Total.	Receipts from Patients, etc.
		£	£	£	£	£	£
1911	1,405 49,782	100	68	445	25	638	98
		Ap. Tbs.					
1912	1,539 48,871	£54 £38	57	451	24	624	83
1913	1,401 40,130	£5 £40	93	446	28	612	29
1914	1,439 32,518	£14 £25	63	461	29	592	32
1915	1,699 42,153	£21 £38	46	446	40	591	26

Under Salaries are included payments made to the Physician and Surgeon in charge of the Departments, the Electrician, the Sister in charge of the Light Department, nine Probationers, and two Wardmaids. The Board and Uniform of the Nursing and Domestic Staff are not included.

MEDICAL RADIOGRAPHIC DEPARTMENT.

Year.	Apparatus.	Repairs and General Sundries.	Photo-graphic Materials.	Development of Plates.	Cleaning.	Honor. of Radio-rapher.	Current.	Total.
	£	£	£	£	£	£	s. d.	£
1911	18	18	64	—	£1 10s.	100	11 6	202
1912	44	32	80	—	£3 5s.	100	5 0	260
1913	8	26	76	—	£3 5s.	—	11 0	114
	Ap. Tbs.							
1914	£4 £33	15	53	—	£3 5s.	—	5 0	109
1915	£279 £55	8	55	—	£3 10s.	—	7 0	401

SURGICAL RADIOGRAPHIC DEPARTMENT.

Year.	Apparatus and Tubes.	Repairs and General Sundries.	Photo-graphic Materials,	Cleaning.	Honor. of Radio-graphers.	Current.	Total.
	£	£	£	£ s. d.	£	£ s. d.	£
1911	127	33	255	2 0 0	250	1 1 6	668
	Ap. Tbs.						
1912	£358 £99	35	197	3 5 0	254	0 12 6	947
1913	13 163	46	154	3 5 0	228	0 11 7	608
1914	11 72	6	132	3 5 0	150	4 9 8	379
1915	34 75	9	137	3 10 0	156	5 0 0	420

PHOTOGRAPHIC DEPARTMENT.

Year.	No. of Patients Photographed.	Plates, etc.	Chemicals.	Cleaning.	*Salary of Photographers.	Total.
		£	£	£	£	£
1911	331	14	43	3	145	205
1912	211	17	63	—	180	260
1913	218	36	52	—	189	277
1914	226	33	27	—	200	260
1915	181	30	27	—	201	258

*Salaries do not include War Allowance or National Insurance.

MEDICAL SKIAGRAPHIC DEPARTMENT

(and Work done for Physicians in Surgical Skiagraphic Department).

In-Patients.		Out-Patients.		Cost of Plates.	Cost of Paper.	Total.
Screened.	Skiagraphed.	Screened.	Skiagraphed.			
				£ s. d.	£ s. d.	£ s. d.
980	401	562	186	46 0 7	4 4 2	50 4 9

SURGICAL RADIOGRAPHIC DEPARTMENT.

					£ s. d.	£ s. d.	£ s. d.
Sir Arbuthnot Lane ...	41	260	—	1	17 18 7	0 13 2	18 11 9
Mr. Dunn	78	208	—	—	13 4 6	0 0 2	13 4 8
Sir Alfred Fripp	99	192	—	—	11 16 11	—	11 16 11
Mr. Steward	75	142	—	—	9 4 1	0 1 8	9 5 9
Mr. Fagge	21	45	—	—	2 16 11	0 2 7	2 19 6
Mr. Rowlands	25	37	—	—	1 18 11	0 0 3	1 19 2
Mr. Turner (Mr. Trethowan)	21	41	—	—	1 19 10	0 1 4	2 1 2
Mr. Hughes	37	53	9	16	3 10 7	0 0 3	3 10 10
Mr. Davies-Colley	—	—	—	—	—	—	—
Specialists	20	34	98	104	7 18 4	4 8 9	12 7
Surgery	—	—	3,464	593	30 14 3	—	30 14
Dental Department ...	—	1	2	13	0 9 11	—	0 9
Bright Ward	5	17	—	—	1 18 11	0 1 11	2 0 1
Officers' Section	47	178	—	4	14 6 4	1 1 5	15 7 9
X-Ray Department ...	—	—	—	—	0 18 1	1 9 2	2 7 3
	469	1,208	3,573	731	£118 16 2	£8 0 8	£126 16 10

MEDICAL SKIAGRAPHIC DEPARTMENT (ANALYSED).

	In-Patients.		Out-Patients.		Cost of Plates.	Cost of Paper.	Total.
	Screened.	Skiag.	Screened.	Skiag.	£ s. d.	£ s. d.	£ s. d.
Dr. Hale White	—	2	—	—	0 2 4	—	0 2 4
Dr. Shaw	5	9	—	—	0 14 5	—	0 14 5
Dr. Fawcett	3	6	—	—	0 11 5	—	0 11 5
Dr. Beddard	2	4	—	—	0 5 8	—	0 5 8
Dr. French	4	1	3	1	0 2 9	—	0 2 9
Dr. Hertz	—	2	—	3	0 5 1	—	0 5 1
Dr. Cameron	3	5	7	9	0 19 0	0 1 6	1 0 6
Dr. Mutch	1	—	—	—	—	—	—
Medical Out-Patients	—	—	3	—	—	—	—
Medical Skiagraphic Department	962	372	549	173	42 19 11	4 2 8	47 2 7
	980	401	562	186	46 0 7	4 4 2	50 4 9

SPECIALISTS (ANALYSED).

	In-Patients.		Out-Patients.		Cost of Plates.	Cost of Paper.	Total.
	Screened.	Skiag.	Screened.	Skiag.	£ s. d.	£ s. d.	£ s. d.
Mr. Eason	—	2	—	—	0 3 11	—	0 3 11
Mr. Ormond	—	2	—	—	0 3 6	—	0 3 6
Mr. B. Smith...	3	4	—	—	0 4 1	—	0 4 1
Mr. Chapple	4	—	—	—	—	—	—
Mr. Mollison	—	2	—	—	0 1 11	—	0 1 11
Mr, Thompson	9	5	1	—	0 6 7	—	0 6 7
Mr. Trethowan	3	16	88	99	6 12 6	0 4 5	6 16 11
Dr. Eyre	—	—	9	3	0 2 4	0 1 3	0 3 7
Mr. Bromley	—	—	—	—	—	0 0 4	0 0 4
Mr. Todd	—	—	—	—	—	0 3 5	0 3 5
Mr. Saner	1	3	—	2	0 3 6	0 0 2	0 3 8
Mr, Shenton	—	—	—	—	—	3 17 6	3 17 6
Mr. Eccles	—	—	—	—	—	0 1 8	0 1 8
	20	34	98	104	£7 18 4	£4 8 9	£12 7 1

Fashion in Physic.

When cardiac twinges cause thee frenzy,
Send and seek Sir James Mackenzie.
If thy grief is hypogastric,
Herschell's remedies are drastic.
If shell shock thy mind is troubling,
C.O. says, "Mott, thy blood is bubbling."
If septic wounds thy strength are shaking.
Whose advice wilt thou be taking?
Cheyne, revering Joseph Lister,
Says, "Bring me quickly phenol, Sister."
"Oh, no, no," says Almwroth Wright,
Don't paralyse the phagocyte.
Irrigate with salt the sinus,
And Major will succumb to Minus.
Moynihan, of Leeds, and Dakin,
Chlorine for their God are making.
Of late we haven't seen a figment
Of the famous verdant pigment.
Plain gauze strips no more will serve us,
"Cigarette drains" now preserve us.
If a comminuted femur
Make thee bellow like a steamer,
And thy dinner's served in vain,
Still take a "plate" from Willie Lane.
If after dining thou hast stasis,
Willie's "Op." the latest craze is.
No one can be smart regarded
Unless his colon he's discarded.
If vexed with rheumatoid arthritis,
Notice whether sore thy bite is;
If mastication leave reminders,
Out with all thy thirty grinders;
If thy anæmia prove pernicious,
Same advice is quite judicious.
If human type T.B.'s are making,
Thy poor glands and joints be aching,
Get thy cure from the Cow,
At Lombard Street, the Court called "Plough."
If any of this wisdom fail thee,
And any serious doubts assail thee,
Remember, ere thou blame the serum:
Omne ovum non est verum.

Report of the Gazette Museum of Antiquities, 1915.

IN submitting the Annual Report it is satisfactory to note that the Museum has been considerably improved during the past year. There has been a noticeable falling off in the number of visitors, due, no doubt, to the general disorganisation of the country owing to the war.

Although the additions to the Museum during the period under consideration are few in number, they are all of special interest. Mr. C. H. Wells has kindly presented a four-page autograph letter from the late Rt. Hon. W. E. Gladstone, M.P. (dated October 18th, 1895)—typical of his fluency and eloquence—in which he expresses a hearty interest in the welfare of this hospital.

The Governors of the Hospital have loaned to GUY'S HOSPITAL GAZETTE for exhibition in the Museum of Antiquities the London University Gold Medal awarded to the late Dr. T. Morley Rook in 1852, presented to them by his son, Lt.-Col. Rook.

Two pieces of shrapnel, relics of the Air Raid on London in October last, form another presentation. Of these, one piece fell outside the Superintendent's Office and was found the next day, the other being discovered on the roof of the Surgery on November 18th.

Another show-case (referred to in the last Report) has now been constructed and fixed up. It is similar in every way to the one already there, and occupies the whole of the opposite wall, adding very much to the general appearance of the Museum. The title of the Museum, viz., "The Gazette Museum of Antiquities," has been neatly painted on the door, and is a further improvement. A descriptive catalogue of the various objects in the Museum is being compiled, and will shortly be ready.

(Signed) Wm. WALE,
Hon. Curator.

Notice.

University of London.

Examination conducted by the Board of Examiners for persons presenting Colonial, Indian, and foreign qualifications for exemption, under Statute 116, from the Matriculation Examination.

Persons of nineteen years of age and upwards who present (a) Certificates of Matriculation in Colonial Universities,* of foreign Certificates from an Academical or other educational authority which in the opinion of the Principal indicate that they have attained a standard prima facie involving an education equivalent in their own country to that required in England for Matriculation in this University, may apply for examination before the Board of Examiners under Statute 116 instead of at the Matriculation Examination. This examination can only be held at the University of London.

Persons desirous of appearing before the Board of Examiners under Statute 116 instead of taking the ordinary Matriculation Examination must apply to the External Registrar for a special Form of Entry, stating what Colonial, Indian, or Foreign Certificate they are prepared to produce.

This Form of Entry must be returned to the External Registrar accompanied by a Certificate of Age, by the Certification aforesaid (and a translation thereof where the certificate is not in English), and a Fee of Four Pounds.

An Examination before the Board of Examiners under Statute 116 will be held on Saturday, 13th May, 1916. The written examination will commence at 9.45 a.m., and there will also be a viva-voce test. Candidates desiring to enter for this Examination must return their Entry Forms to the External Registrar on or before Saturday, 29th April, 1916.

For further information application should be made to the External Registrar, University of London, South Kensington, London, S.W.

*Diplomas of Degrees granted by recognised Colonial or Indian Universities entitle the holder thereof, under Statute 116, to registration as Matriculated Students without further Examination.

The Royal Sanitary Institute,

90, BUCKINGHAM PALACE ROAD, S.W.

Conference on Sanitary Administration under War Conditions, London, June 9th and 10th, 1916.

Friday, June 9th, at 10.30 a.m. The Conference will be opened by The Right Hon. the Lord Mayor of London (Sir Charles C. Wakefield, Kt.). Discussion on "The Maintenance of the Standard of Municipal Sanitation during the continuance of War Conditions," To be opened by H. Percy Boulnois, M.Inst.C.E., and James Wheatley, M.D., D.P.H., Medical Officer of Health, Shropshire County Council. The Chair will be taken by His Worship the Mayor of Westminster (Sir George Earle Welby, C.M.G.). 3.0 p.m., Visits to various undertakings allied to Public Health Work.

Saturday, June 10th, at 10.30 a.m. Discussion on "The Mental Deficiency Act from the Social and Educational Standpoint," to be opened by A. B. Ritchie, M.B., C.M.Edin., Medical Officer, Manchester Education Committee. The Chair will be taken by Leslie Scott, K.C., M.P. 3.0 p.m., Visits.

Rugby Football.

UNITED HOSPITALS v. NEW ZEALANDERS.

The Hospitals were not so strong as in their match with the Gloucesters when they faced the New Zealanders at Queen's Club on April 1st. True, A. C. Palmer of London came into the side, and, although short of practice, did well, but Llewellyn of Bart.'s was much missed; he is a very fine player and his absence was very noticeable. Davies and Cockell did not get going anything like the same as Micklem and the Bart.'s man. There we had a combination that worked together naturally, though it should be said they had an easier task than the Davies-Cockell game, because the Gloucesters did not break away and down on to the attack half so swiftly as these hefty men from New Zealand. At half-time the Colonial team were two tries to the good. Hall got one try and Griffiths the other. Neither was converted so that when ends were changed the Hospitals had not scored and the Colonial score stood at 6 points.

Resuming, it cannot be safely said the Hospital team never looked really dangerous. There was far too much kicking ; and as for Curle, except for about a couple of runs, he was completely starved and had no chance at all. Hall for the opposing team showed up well for a line out, getting clean away and putting Fraser across the line for a try, which Muir made an excellent attempt at converting, hitting the post with the kick. Stewart then had a drop at goal from an offside award and only narrowly missed success. Curle now had an opportunity which just failed by the corner, and Palmer tried a shot at goal from a free kick which only missed by inches. It evidently was not the Hospitals' day out. In the closing stages Burns got a fourth unconverted try which put the issue beyond all doubt, leaving a very brisk match with the New Zealanders victorious by 4 tries to nil; 12 points to 0. Mr. Trollope, the London Referee's Association Secretary, was in charge of the whistle.

C. G. Ainsworth (London) (back); W. A. Stewart (London), A. C. Palmer (London), R. S. Woods (St. George's), C. L. Curle (Guy's) (three-quarters); D. H. Cockell (Bart.'s), L. M. Davies (Thomas) (halves); F. M. Mosely (London), H. C. Joyce (Bart.'s), E. A. Fiddian (Bart.'s), S. A .T .Ware (Thomas), C. W. W. Armstrong (Guy's), A. M. J. Smart (Thomas), R. C. Davenport (Bart.'s), D. D. S. Evans (Bart.'s) (forwards).

Birth.

EDMOND.—On Tuesday, April 4th, at 96, Bromley Road, Catford, the wife of John Edmond, M.B., of a daughter.

IREDELL.—On April 2nd, at Cumberland Terrace, Regent's Park, N.W., the wife of Dr. C. E. Iredell, of a son.

Death.

OWEN.—On April 2nd, suddenly, Samuel Walsh Owen, M.R.C.S., L.S.A., in his 66th year.

F. A. K.

GUY'S HOSPITAL GAZETTE.

VOL. XXX., No. 726.] MAY 6, 1916. [SIXPENCE.

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Passim.

THE report of the treatment of British prisoners in the German concentration camp at Wittenberg can be described as a truly terrible document, and would be well nigh incredible were it not for the many parallel crimes and horrors which can be laid to the credit of this country's chief enemy. There is something magnificent in the courage and devotion of the six British doctors who, after six months' imprisonment in Halle, were sent to the Wittenberg camp. Theirs it was to deal with the typhus outbreak before the German authorities had sufficient pluck even remotely to approach the spot. "Schweine Engländer" were the words with which the supposed doctor in charge insulted them as they begged through the wire entanglements for some urgently needed medical requisite.

No wonder that, as we are told, many looked upon typhus, with all its horrors, as a godsend and preferred it to the presence of their German guards. It will be a matter of the greatest satisfaction to all that the King has conferred honours upon the three survivors of this heroic band—Major Priestley, Captain Vidal and Captain Lauder.

AN advisory committee has now been formed by the Royal College of Physicians of London and the Royal College of Surgeons of England to give advice to the Government in relation to medical men in the metropolitan district required for service in the army, and to assist in cases of special difficulty arising elsewhere in England and Wales and coming before the central tribunal of the Military Service Act.

The names given are Dr. Frederick Taylor, Dr. J. Galloway, Dr. Sidney Martin, Dr. W. Pasteur, Sir W. Watson Cheyne, Sir Rickman J. Godlee, Mr. William F. Haslam, Mr. D'Arcy Power, and Mr. Chas. Ryall. The Joint Committee has already commenced its sittings at the Royal College of Physicians, and Mr. F. G. Hallett is acting as secretary.

It has been agreed from the outset that opinions and decisions of the advisory committee would be transmitted to the Governmental Department *via* the Central Medical War Committee without alteration.

The College of Surgeons has made the further suggestion that a preliminary survey may be made of the minimum necessities of the metropolitan hospitals and schools in respect of staff.

THE Residents' "Going off" Dinner, held in the College on Saturday, April 29th, for merri-

ment and good speeches, was an unqualified success.

We heartily endorse the words of praise and appreciation so ably spoken. Messrs. Kendall (President), Burnside (Vice-President) and Richards were the Residents retiring.

ONCE more the rumour is in the air that before many months are past the female house officer may become a general necessity in the metropolitan districts. Already we hear that St. Mary's Hospital is offering temporary accommodation to the overflow of students from the Royal Free Hospital for Women, and although we understand that this arrangement is of a purely temporary description, still it is suggestive of future changes.

WE are glad to hear of the return of Dr. Shaw to hospital and wards, and heartily congratulate him upon his recovery.

WE regret to hear the following news of two Guy's men :—

MISSING.—(Believed killed), 2nd Lieut. J. C. Robertson, Cameron Highlanders, was reported missing after a charge by his regiment, across a canal in France, under heavy fire. This was in May of last year (1915). Enquiries through every possible source have failed to trace him. His name has not appeared in any list of prisoners of war, and no communication has been received from him. Entered as Medical and Dental Student in October, 1912. Joined the Camerons in September, 1914.

WOUNDED.—2nd Lieut. H. J. Barrand, 9th Leicesters, has been reported wounded on the Eastern Front.

Pass List.

Society of Apothecaries of London.

At the examination held recently the following candidates passed in the subjects indicated :—

Surgery, Sect. I. and II.—E. N. Glover.

Forensic Medicine—M. B. M. Tweed.

The Diploma of the Society was granted to E. N. Glover, entitling him to practise in medicine, surgery and midwifery.

Letters from France.

I.

Quand la guerre s'ra finie
Tous les anglais partis. . .

This, just at present, is the burden of everyone's song out here; not that people want to get rid of us, or at least so we fondly imagine, but because the departure of *les engleesh* after all these months of peaceful invasion will leave a blank in the life of this tranquil little town that will for long be felt. It is a standing marvel to me to see the way in which the French as a people have adapted themselves to the life of their allies. Contrast, for a moment, the small impression made at home by the advent of the Belgian refugees with the profound effect of the English occupation out here, and the most sceptical will begin to believe in the Englishman's genius for colonization. It is not a question, as is sometimes said, of British adaptability, for your Britisher is the least easily moulded animal in the world, it is most certainly not a genius for organization (in the German sense, at all events) ; it is, I think, a combination of lavish expenditure and good-humoured insularity, and—softly be it said—a little easy-going contempt for everything that is not quite solid and British and roast beefy-ied and consequently tending to be foreign, and ramshackle, and, in a word, "made up." Before the war the acute observer could have detected this tendency in the little shops which line the quays in any seaport town, where English meals, very expensive and very unpalatable, English tobaccos, and the little triangles denoting the beer that is Bass's were to be seen tempting the mariners of England, but your sailor is always a cosmopolitan, making the most of life wherever he finds it, and the signs were but superficial. Moreover, the Englishman in spite of his reputation, is not at heart an easy traveller, and those who seek their fortunes in the colonies pass merely from home to a replica of the mother country. In no city of the world is there a settlement of English comparable with the Italian quarter in New York or Paris or the French quarter in London. Never before have the industrial classes of Britain been brought into close contact with the life of a continental people. The educated, and hence the travelling class of any nation tends to approximate to a definite type; a Japanese scholar or diplomatist meets his Western confrères on equal terms ; it is amongst the people that racial characteristics are most marked and survive the longest. This conservatism, moreover, is most noticeable in those districts which have been the least exposed to the admixture of foreign elements : the Lancashire man is more national that the Londoner, the Scot than either. The effect of their

sudden and violent transplanting to a foreign shore has been both interesting and fruitful. At first the result was not altogether a happy one. The French conception of an Englishman was that of an extremely eccentric but wealthy individual, addicted to *le whisky* and *le sport* (this last a sure proof of madness, for who but he would be so foolish as to work when there was no need); the (popular) concept of a Frenchman, a light-headed and amorous creature, talking in moments of patriotic enthusiasm of "*la gloire*," but whose worth in comparison with our own the Waterloo affair had demonstrated for all time. Consider, then, the mutual surprise when each developed in the eyes of the other unsuspected qualities of sternness, bravery, and, most dangerous of all, a common humanity. The illusion was shattered; what wonder that the creation of a truer picture was, in the making, an anxious process. But now that we and our allies have got used to each other, when the little frictions and bitternesses inevitable at the outset have been smoothed away, one can form some idea of the influence that our stay will have upon our own soldiery and upon the townsfolk of the countless 'somewhere's in France' where troops pass, are billeted, ordered on again, fight, and die. Most striking, perhaps, on first sight, is the introduction of the English 'walking out' custom. Before the war it would have been an unheard-of thing for two *fiancés,* or, indeed, any couple who valued their reputation to be seen walking in any but the most crowded thoroughfares in each other's company. But now the country roads are as crowded as any English lane with couples who (*pace* Maeterlinck) *sortent enlacés, promenading* with the astonishing *naiveté* which marks your Saxon swain the world over. It would be pretty speculation to know what comes of these walks, to the callous eye monotonous to the verge of extinction. Tommy is sheepish and monosyllabic, the laboriously acquired French of Stratford-atte-Bow failing miserably in this heroic test; the lady self-conscious, a little awkward in her outgoing finery, awed, perhaps, at this taciturn lover, so different from her own more volatile menfolk. And then the exchange of post-cards: you know the sort of things, a *poilu* impossibly clean and bandboxified bidding farewell to a weeping Alsacienne (national costume, of course), or a sailor in the uniform they wear in "Butterfly" at the Opéra Comique, writing to his sweetheart (inset, the sweetheart writing to her *matelot*), all scrawled over with little crosses and "*mille baisers pour ma très cherie,*" or "Goodbye- Darling." Very silly and sentimental, isn't it? *mais sans doute elle a vraiment un béguin pour son Tommy.* One wonders a little curiously what Clara or Lily, way back in Blighty, would say if they came across (and, who knows, they may) some of these effusions. After the war the gay and godless French, as an old aunt of mine used to say, will have a lot to answer for.

If the war has been responsible for the introduction of the verb "to strafe" into the English tongue, it has certainly enriched the French by "*le cafard.*" If you were to ask a *poilu* what he meant by *le cafard* he would probably make an inimitable gesture and reply "*le typhus, quoi!*" Don't run away with the idea, for all that, that when an advertisement speaks of something as good "*pour tuer le cafard*" it is the typhus bacillus which is to be strafed. Not at all; *le cafard* is that deadly enemy, the blues, and that, believe me, is the enemy our gallant allies fear the most. By far the most popular remedy for its destruction seems to lie in the chances of correspondence with a fair unknown, and many are the amusing notices which appear soliciting the aid of a *marraine* (a *marraine, cher lecteur,* may be freely translated as "guardian angel"). As you will expect, they don't stop at the English-girl-would-write-cheery-letters-to-a-really-lonely-officer style of thing which adorns the agony column of the *Times.* "*Jeune poilu imberbe*" is a favourite opener, the usual requirements are a "*Parisienne, gaie, spirituelle, fort jolie,*" or, perhaps, "*rêveuse, éprise d'inconnu,*" who will be willing to help the aforesaid *poilu* in killing his *cafard.* But some of the gems from my collection I must reserve for another letter. A few, gentle reader, might shock your sense of propriety, but, after all, as we say out here, "*C'est la guerre, ca change tout, ca explique tout, et ca pardonne beaucoup,*"—and quite right, too.

G. H. F. G.

Change of Address.

A. H. Miller, M.A., M.D., B.C., from Foxton Hall, Royston, Herts, to Pampisford Vicarage, near Cambridge.

E. O. Yerbury, L.D.S. (of Temple House, Lyme Regis), Artists Rifles, 28th County of London Regiment.

V. Drew, Esq., 2nd Lieut. 9th D.C.L.I., attached to Young Officers' Company, 10th (Reserve) Infantry Brigade, Swanage, Dorset.

2nd Lieut. W. R. Ransford, I.A.R.O., 2/10th Gurkha Rifles, from Lansdowne, Garhwal, to Quetta, Baluchistan, India.

Henry Horsley, 1, Poplar Walk, North End, Croydon.

Roy. N. Craig, Lieut. in R.A.M.C., is now attached to the 136th Field Ambulance, now stationed at Fleet.

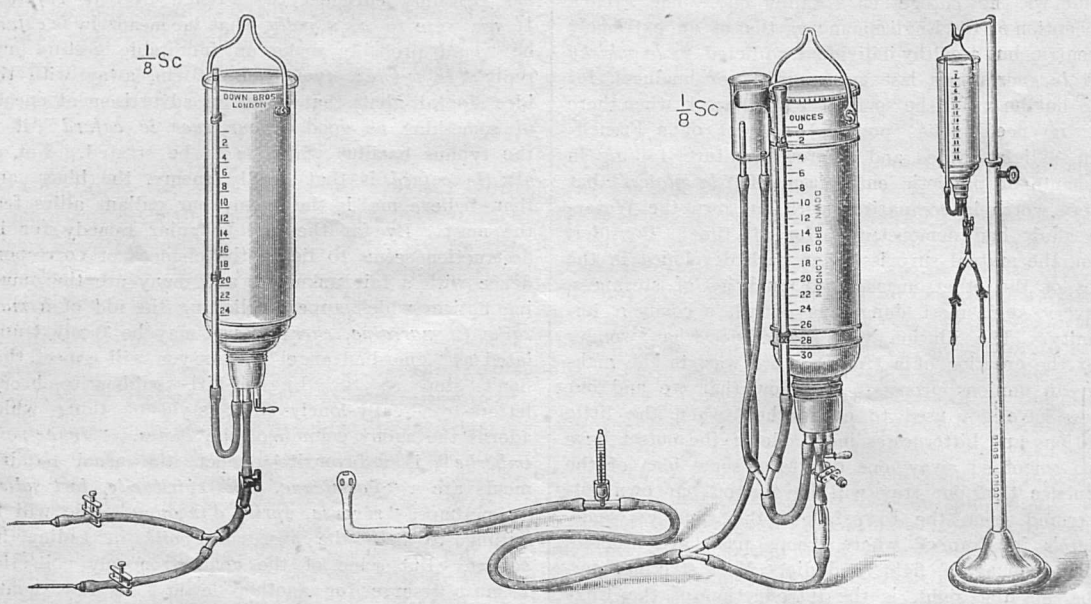
Lieut. F. R. Wallis, 3rd Southern General Hospital, Oxford.

Capt. G. Y. Thomson, I.M.S., No. 10 General Hospital, Busra, Mesopotamia.

H. Bowen Perkins (late of Bettws-y-Coed, North Wales), 5, Trevor Terrace, Tilbury.

(The Editor will be very glad to receive a post card with notes of any change of address.)

An Improved Apparatus for Saline Infusions.



Some time ago (vide *British Medical Journal*, 30th September, 1911), I drew attention to the fact that it was practically impossible to ensure saline being infused *hot* into the tissues by means of the apparatus at that time in use.

It is of the utmost importance that fluid introduced subcutaneously in cases of severe collapse or shock should be hot, because even a slight drop in the body temperature, which is already subnormal, may make all the difference between recovery and death. Especially is this the case in children, for they stand exposure to cold badly. Moreover, hot saline is more readily absorbed than cold, which constricts the vessels in the area infused.

The apparatus which I suggested to fulfil this object has had a thorough test extending over a period of four years. It has given good results in cases of summer diarrhœa in children, in post-partum hæmorrhage, and in other complaints in which the body is deprived of fluid, but practical experience has resulted in two minor disadvantages being revealed. In the hands of some users the indicator did not work accurately; owing to saline entering the air-pipe and creating a partial obstruction to the intake of air, the indicator oscillated violently. The other fault was that the cork, unless firmly put in, was liable to fall out.

Messrs. Down Bros. have kindly made for me a new instrument closely resembling the original, but designed to do away with all the shortcomings of its predecessor. The essential part is a vacuum flask with a screw-cap carrying a rubber cork, which is pierced by two short glass tubes, and a long metal one extending to the bottom of the flask. One tube is connected by a piece of rubber tubing to a glass tube graduated in ounces, and firmly attached to the case of the flask. This constitutes the indicator, or water gauge, when the flask is inverted. The other glass tube is attached to thick rubber tubing which conveys the fluid through a "Y" piece, and two needles specially made with side holes. The object of these holes is to maintain the flow of saline should the mouth of the needle become obstructed by a piece of tissue while being introduced through the skin. The long metal tube, which is fitted with a stopper at the distal end, but controlled from the proximal end, serves as an air inlet when the instrument is in use. In order to prevent loss of heat, the length of tubing between the flask and the needles is reduced to a minimum, and does not exceed ten inches. A handle is attached for suspending the flask above the bed, or on a suitable stand. The whole apparatus is extremely simple and easy to work. Once the saline is started it requires no further attention beyond clipping it off when the patient has had the prescribed amount. It holds 30 ozs., and the saline in it will remain hot for at least six hours.

The directions for use are simple. Fill the flask with saline at a temperature of 135° F. Close the end of the long tube by means of the stopper, and screw down the rubber cork and cap. Connect the glass indicator to the rubber tubing, and invert the instrument. Open the stopper, air will enter the flask, and

the water gauge will at once come into action. Allow the saline to flow from the needle at the rate of between six and twelve ounces an hour, and it will enter the patient's tissues at a temperature of between 95° and 105° F. The amount infused, and the rate of flow, can be ascertained from a glance at the indicator, and regulated as desired by the screw clips.

For those who wish to use this type of apparatus for rectal infusion, it is also made fitted with the addition of a regurgitation funnel, etc., as described by Magnuson in his article on the Murphy Method of Rectal Proctoclysis (*vide* Surgery, Gynæcology, and Obstetrics, February 2nd, 1910).

The presence of the drop indicator and the longer tubing, which it is necessary to use when giving rectal infusions, will naturally tend to lower the temperature of the saline solution. This may be overcome to a certain extent by wrapping the tube in flannel, or, if preferred, the glass "T" piece carrying the thermometer may be removed and the rectal pipe inserted in its place, in order to keep the rubber tubing as short as is practicable for each individual case.

N. STUART CARRUTHERS.

Papers by Guy's Men.

Capt. G. T. Mullally, M.B., B.S. Lond., F.R.C.S. Eng., R.A.M.C. Special Reserve: A case of tetanus-like spasm localised to the wounded limb.—*Lancet*, April 22nd, 1916.

Temp. Capt. H. C. Lucey, M.D., B.S.Lond., R.A.M.C.: The therapeutic and reaction effect of Kharsivan: A record of 600 injections.—*The B.M.J.*, April 29th, 1916.

Capt. W. Sampson Handley, M.S., F.R.C.S., R.A.M.C.: Jejunostomy and jejuno-colostomy: a reply.—*Ibid.*

Sir James Goodhart, Bart., M.D. Aberd., F.R.C.P. Lond.: On pneumococcal bronchitis.—*Lancet*, April 29th, 1916.

E. W. Ainley Walker, M.A., M.D. Oxon.: Influence of febrile conditions on inoculation agglutinins: a reply.—*Ibid.*

W. M. Mollison, M.C.: Case of hypopharyngeal carcinoma: removal: restoration of the wall by turning in a piece of skin.—*Proceedings of the Royal Society of Medicine*, March, 1916.

J. G. Stevens, M.D., F.R.C.S.: Adenomyoma of the recto-vaginal septum.—*Ibid.*

J. Lewin Payne, M.R.C.S., L.R.C.P., L.D.S., Montagu F. Hopson, L.D.S., R.C.S., P. P. Cole, M.B., B.Ch., F.R.C.S., and F. J. Pearce, L.D.S., R.C.S.: War injuries of the jaw and face.—*Odontological Section, Ibid.*

The Massage Department.

EXTRACTED from a letter from Dr. E. P. Poulton, we have the following list of conditions in which physical remedial exercises have been employed. They are divided into (1) A general group of diseases; (2) A special group on which investigations are at present being carried on.

GENERAL GROUP.

Nervous Diseases of all kinds, especially—
- Cerebral and Spinal Syphilis.
- Tabes, and G.P.I.
- Disseminated Sclerosis.
- Progressive Muscular Atrophy, etc.
- Poliomyelitis.
- Muscular Dystrophies.
- Hysteria.
- Neurasthenia.
- Neuritis.
- Neuralgia.

Circulatory Diseases, especially—
- Cases of Cardiac Disease, compensated and uncompensated.

Respiratory Diseases, especially—
- Chronic Bronchitis and Emphysema.
- Unresolved Pneumonia.
- Fibroid Lung.
- Empyema, as soon after operation as possible.
- Pleurisy, with and without effusion.

Alimentary Diseases, especially—
- Chronic Gastritis.
- Dyspepsia.
- Visceroptosis.
- Constipation.

Genito-Urinary Diseases, especially—
- Delayed Menstruation.
- Painful Menstruation.
- Chronic Bright's Disease.

Other Diseases—
- Blood Diseases, especially Chlorosis.
- Diabetes (mild cases).
- Gout.
- Obesity.

SPECIAL GROUP.

The following investigations are being pursued in the Department at the present time, and it is hoped that suitable cases may be sent for this purpose.

(1.) The Effect of Graduated Exercises in Cardiac Disease, including the functional testing of the heart's condition throughout the treatment.

(2.) The Effect of Exercises on certain respiratory disorders, with the object of discovering a system of treatment based on sound principles, for localised disease of the lungs and pleuræ, *e.g.*, localised fibrosis, empyema, pleural effusion, unresolved pneumonia, etc.

A Method of Treating General Peritonitis with Obstruction,

And its application in Military Surgery.

By W. SAMPSON HANDLEY, M.S., F.R.C.S.,
Captain R.A.M.C. (T.).

(With acknowledgments to the *B.M.J.*)

(Continued)

Treatment by Jejuno-transverse-colostomy with Cæcostomy.

If a jejuno-colostomy is made between the jejunum low down and the middle of the transverse colon, uncontaminated fluid taken into the stomach is passed along the unparalysed jejunum into an unparalysed portion of the large intestine, where it can be absorbed. But the cæcum and the rest of the colon are paralysed, and there is no outlet from the transverse colon. Distension of the cæcum would follow the operation, and rupture of this viscus might be expected. Here, as in ileus duplex, temporary provision must be made for draining the cæcum until the inflamed large bowel has recovered its peristaltic power.

My scheme of treatment, then, is as follows—

1. For pelvic peritonitis and intestinal obstruction (ileus duplex) consequent thereon—ileo-colostomy to the ascending colon with cæcostomy (Fig. 1).

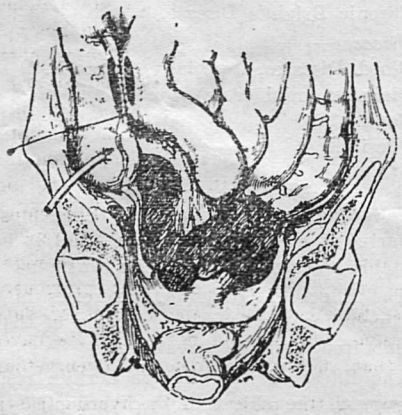


Fig. 1.—Ileus duplex (paralytic obstruction secondary to pelvic peritonitis). Treatment by ileo-colostomy and cæcostomy.

2. For so-called "general peritonitis," that is, unlocalised peritonitis, extending roughly up to the level of the umbilicus, with intestinal obstruction (hypogastric ileus), jejuno-colostomy to the transverse colon, with cæcostomy (Fig. 2).

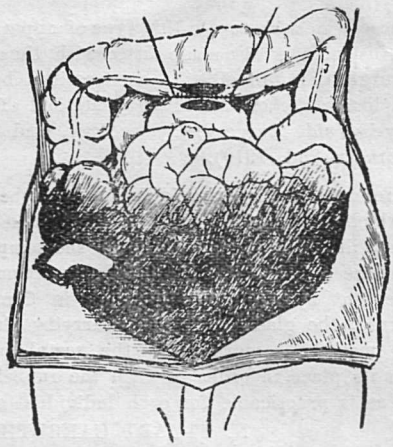


Fig. 2.—Hypogastric ileus (paralytic obstruction of early general peritonitis). Treatment by jejuno-transverse-colostomy and cæcostomy.

In all cases pelvic drainage must be provided.

The advantages gained by such an emergency alimentary canal—consisting of stomach, jejunum, transverse and ascending colon and cæcum—are numerous. The normal intestinal current is restored, vomiting ceases, the stomach is not fouled by a reflex of septic intestinal fluid, and becomes once again a clean vessel apt for the digestive processes. For it is clear that fluid regurgitating from the lower intestine will rather pass through the jejuno-colostomy opening into the colon than face the tortuous and active resistance of the jejunum. The jejunum itself receives only the uncontaminated products of digestion from above, and intestinal digestion and absorption can take place unhindered. It is true that the colon will still contain septic fluid regurgitated from below, but the absorptive power of the colon for aught but water is negligible. The colon can perform its important function of water absorption even when its contents are laden with bacteria—their normal condition.

Thus provided with clean food and fluid—the things he most requires—the prospects of the

patient's fight with his peritoneal infection are vastly improved.

It may be objected that the steps taken to re-establish the intestinal current will be defeated by the continued upward spread of the peritonitis. In a proportion of cases where the peritoneal infection is virulent this objection is doubtless valid. But it omits to take into account the probability that in many cases intestinal paralysis is the main factor determining the continued spread of the peritonitis. It is well known that distension of a hollow viscus interferes with its blood supply, impairs its nutrition, and renders its walls pervious to the bacteria within. There is every reason to hope that in many cases the relief of the distension in the upper gut will turn the scale in the patient's favour by arresting the further upward spread of the peritonitis. Strong evidence in favour of the supposition is provided by the success of similar treatment in arresting the upward spread of pelvic peritonitis in cases of ileus duplex.

Technique of Jejuno-transverse-colostomy.

The operation of jejuno-colostomy can be quickly and easily carried out without evisceration of the intestines and practically without shock. An incision four inches long and extending down to a point one inch below the umbilicus, is made through the middle of the right or left rectus muscle. The lower border of the transverse colon is exposed and identified and pulled forward. The great omentum is torn through just below the gut, and two fingers are introduced through the rent to seek for a suitable coil of jejunum. The coil selected, like all the small intestine, will be distended, and may be congested, but it should not have lost its lustre or its resilience. It is drawn forwards into the wound, where it lies just below the fold of transverse colon, which has also been withdrawn. Clamps are applied to the two selected pieces of gut, and a lateral anastomosis is made in the ordinary way. The anastomosis can be strengthened subsequently, if desired, by sewing down the great omentum to the surface of the jejunum. The bowel is returned, the incision is sewn up, and a cæcostomy is performed in the ordinary way through a separate incision. It is well to tie a Paul's tube in the cæcum, but experience may show that a large rubber catheter does equally well.

A Case where the Treatment was Successfully Applied.

An opportunity was lately presented to me, in a case now to be described, of testing the validity of the chain of reasoning I have laid before the reader.

Miss H., aged 30, had for some months complained of vague abdominal pain at intervals, but had not sought medical advice.

On December 29th, 1915, she was taken ill with what was supposed to be a chill on the liver. She kept at her work and did not consult a doctor. The following day vomiting began, and was repeated soon after she took a purgative. The abdominal pain, of a colicky character, was situated in the lower part of the abdomen. On December 31st she went to town as usual, but was sick and ill, and the pain persisted. On January 1st she was worse, and was then first seen by Dr. A. J. Hogg, of Ealing. He found that she had general severe abdominal pain and tenderness, worse on the left side. There was little movement of the abdomen on breathing. The vomiting had been bilious, and the temperature was 100°, the pulse about 90. At 6 p.m. on the same day the pulse was quicker and the temperature higher. There was great pain in the lower part of the abdomen, and she lay on her back with her legs drawn up. On this day for the first time there was pain on micturition, and in the evening Dr. Hogg asked me to see her with him with a view to operation. About 10 p.m., when I saw her, her pulse was 120, her colour good, and she did not appear to be in much distress. There was slight general abdominal distension, and the abdomen moved to a certain extent with respiration. There was no true abdominal rigidity. In the right iliac fossa an indefinite resistance could be felt. On pelvic examination there was extreme tenderness in the region of the pouch of Douglas, with fixation of the uterus, thickening of the right utero-sacral fold, and some resistance of the right broad ligament. The periods were regular, the last one having ceased a fortnight previously. The patient's statements as to the passage of flatus were rather vague, but she did not appear to have passed it more than once in the preceding twenty-four hours.

In view of the early colicky hypogastric pain, of the signs on the right side of the pelvis, and of the pain on micturition, together with the absence of abdominal rigidity and the presence of resistance in the

appendix region probably due to swollen ileo-colic glands, we arrived at the conclusion that the patient was suffering from pelvic appendicitis. It was thought, in view of the continued vomiting, that intestinal obstruction was likely to complicate the case.

First Operation. — Immediate operation was decided upon, and a median hypogastric incision was made. On opening the peritoneum a certain amount of clear fluid escaped. The omentum was adherent in the pelvis, and on separation it was found to be sloughing at its tip. The coils of small intestine, which now came into view, were rather congested, but had not lost their lustre. The pelvis was packed off from the rest of the abdomen, and on passing the hand down into it, some ounces of thick pus escaped, and a mass was found which on extraction proved to be a swollen and gangrenous appendix containing two large concretions. There was superficial sloughing of a portion of the cæcum near the base of the appendix. All the intestines in the lower abdomen were distended by flatus and rather congested, but there were no areas of œdematous, collapsed, and deeply-congested intestine such as are seen in typical cases of ileus duplex. The condition appeared to be general paresis of the pelvic and suprapelvic intestines without actual paralysis, and it seemed likely that eserine and pituitary extract would maintain peristalsis in the damaged gut, but it appeared safer to tie a catheter into the cæcum and bring it out through the median wound. The pelvis was drained by two large tubes.

After the operation the patient was placed in the Fowler position, saline was administered subcutaneously to the extent of about six pints for the first twenty-four hours, and injections of eserine salicylate were given every six hours in order to produce intestinal contractions. The catheter, either because it was blocked, or because there were no contractions in the intestine, did not act. Turpentine enemas were given, but only produced a little fæcal-stained fluid, and no flatus passed per anum. A purgative failed to act, and forty-eight hours after the operation the condition of the patient was most alarming. The abdomen up to the umbilicus was rigid, hard, and tensely distended like a football. Above the umbilicus the distension was not so marked; rigidity was absent, and there was some abdominal movement with respiration. The pulse had risen in frequency. The patient was not sick, but was troubled by constant feelings of nausea which made her unwilling to take nourishment.

Second Operation.—Since I have never seen a patient recover from a similar condition of general peritonitis with complete obstruction, I told the friends recovery was improbable in any circumstances, and certainly impossible unless something further was done. It appeared certain that the peritonitis had extended as high as the level of the umbilicus, and that the whole of the ileum and the lower colon were suffering from paralysis, the result of the peritonitis. The condition of the abdomen above the umiblicus showed, however, that the upper part of the small intestine—say, roughly, the whole of the jejunum—was still capable of normal peristalsis. Though the ascending and descending colon were probably paralytic, the transverse colon lying at the upper limit of the peritonitic area might be presumed still to retain its contractile power. A lateral anastomosis between the lower jejunum and the transverse colon seemed, therefore, to be the rational method of treatment if combined with a cæcostomy to afford a free exit for the contents of the large intestine.

The friends of the patient consented to further operative measures, and through an incision 4 inches long situated $1\frac{1}{2}$ inches to the right of the middle line and extending downwards to an inch below the umbilicus, I re-opened the abdomen.

The incision exposed the lower border of the transverse colon, which was distended by flatus and apparently not inflamed. Just below the transverse colon I tore through the great omentum and thus obtained access to the upper small intestine. The first coils it presented (belonging probably to the upper ileum or lower jejunum) were too much distended and inflamed to permit of their use for the lateral anastomosis, a proof that the peritonitis had actually extended up to the umbilicus. Two fingers introduced in a direction upwards to the left succeeded in withdrawing a higher coil which, though distended, was not inflamed. This coil was brought forward in the opening in the great omentum and clamped. A clamp was next applied to the closely adjoining portion of the transverse colon, which also had been brought out into the wound. The area was packed off, and a lateral anastomosis was made in the usual way. Since the small intestine, owing to distension and slight œdema, did not hold stitches well, a portion of the great omentum was drawn down over the suture line so as to strengthen it. The bowel was returned and the abdominal incision was sewn up. The cæcum was next sought in the original wound at the point where the catheter was tied in it, and here a Paul's tube was inserted.

After-History.—The patient bore the operation well, and her pulse at the end of it was about 120. It should be added, as indicating the virulence of the bacteria present, that the whole of the surfaces of the original incision were at this time covered by a superficial grey slough. The result of this operation was most satisfactory. It was followed by the administration of a purgative, and the following day the colotomy had acted well. A certain amount of fluid material together with flatus had also passed by the anus. The lower abdomen, though still tender, had lost its tension, and the rigidity was less marked.

Three days after the operation a tender swelling developed in the right iliac region. There was also some suppuration of the incision of the second operation. The right iliac swelling was opened two days later, and proved to be an abscess in the abdominal parietes, probably due to extension of infection from the region of the second operation. No leakage took place at the lateral anastomosis. When the Paul's tube came out there was a considerable escape of semifluid intestinal contents from the cæcostomy, and the bowels also continued to act per anum. The patient's temperature fell, the wound assumed a healthy aspect, and her appetite returned. For some time after the operation a fluid action of the colotomy wound followed each meal. Nutrition rapidly improved and strength returned. The cæcostomy wound has contracted, and will, no doubt, soon close.

The anæsthetics were given by Mr. Herbert Charles. I am indebted to Drs. A. J. Hogg and W. B. Stanford for their unremitting care in the after-treatment, which alone rendered recovery possible.

Conclusion.

The condition of a patient suffering from general peritonitis which is spreading upwards through his abdomen may be compared with the predicament of a house invaded by a rising flood. The householder can only survive the crisis if he retires upwards to the first floor. There he must improvise arrangements for carrying out in a rudimentary fashion the primary needs of existence. There he must cook, eat, and sleep until the flood subsides. The essence of this paper is a suggestion that a similar policy may save patients attacked by the rising flood of a general peritonitis.

Treatment of Gunshot Wounds of the Abdomen

Colonel Cuthbert Wallace[2] tells us that men shot through the abdomen die mainly from one of three causes: hæmorrhage, peritonitis, or intestinal obstruction following peritonitis. Most of the deaths from hæmorrhage will take place before the hospital is reached. In the survivors an early operation for suturing or resection of the bowel may avert the dangers of peritonitis and obstruction. It is a triumph of surgery, and still more of organization, that operations of this character are now relatively successful. In wounds of the small gut, when the patient arrives in a condition that permits operation, Colonel Wallace[3] and his colleagues have secured about 50 per cent. of recoveries, a remarkable result when it is borne in mind that the mortality of expectant treatment is 100 per cent.[4] It is an unsolved problem how many of the residual cases die after operation from the mere intensity of the peritoneal inflammation. It seems likely that some of these cases are capable of recovery from the peritonitis alone, but that their chance is spoilt by the onset of obstruction. To such cases the method suggested in this paper is clearly applicable, and possibly with success.

But, though its hypotheses have been stated dogmatically for the sake of emphasis, my paper is to be regarded as suggestive only. I hold no brief for my conclusions, and only ask that they should be tested. It is unnecessary to offer a defence against the charge of premature publication, for at the present crisis many rules, usually salutary, must be suspended in the public interest for the duration of the war.

REFERENCES.

[1] *British Journal of Surgery*, vol. iii., No. 10, 1915.
[2] *Lancet*, December 18th, 1915.
[3] *Lancet*, March 4th, 1915.
[4] Delore, *Lyon Chirurgical*, September, 1915.

An Appeal.

Matron's House,
Guy's Hospital,
May 1st, 1916.

Dear Sir,

May I ask for your help in support of an appeal I have had from Flanders for 15 football jerseys and shorts for an R.F.A. team.

The jerseys need not be any special color or size; they will all be mended, and, if necessary, dyed before being sent out, and they may be directed to me at the above address.

Yours faithfully,
L. V. HAUGHTON.

Roll of Honour.

Died of wounds: Lieut. Malcolm E. Ball, M.B., R.A.M.C.

Time in Surgery.

BY R. P. ROWLANDS, M.S., F.R.C.S.,
(Surgeon to Guy's Hospital).

THE priceless value of time in surgery is often overlooked, and fleeting opportunities of successful action are frequently allowed to pass with disastrous consequences. Again and again diagnosis is delayed or operation deferred until it is too late either to save life or to secure the best result. For instance, the early signs of grave abdominal diseases are too often attributed to trivial ailments, and a "wait and see" policy adopted until such irreparable damage is wrought that complete recovery is impossible. In such cases the greatest vigilance is required to determine the proper time to "look and see."

Two typical cases of appendicitis serve to illustrate these points. They were very similar in their early signs, but treated differently and attended by very different results.

CASE 1.	CASE 2.
(*a*) Diagnosis made within twelve hours.	(*a*) Diagnosis, abdominal influenza. After nine days, appendical abscess diagnosed.
(*b*) Operation within thirteen hours.	(*b*) Operation after ten days.
(*c*) Appendix removed, gangrenous, but not perforated.	(*c*) Large abscess opened. Appendix not found owing to the large size of abscess and the grave condition.
(*d*) General condition good.	(*d*) General condition very bad.
(*e*) Gridiron incision.	(*e*) Battle incision, as the surgeon thought he could get more room in this way.
(*f*) Abdomen closed.	(*f*) Drainage on and off for six months; then appendix removed at second operation. Drainage another two months.
(*g*) Patient up from fourth day: taken to the country on the ninth day. Quite well three weeks from operation.	(*g*) Patient up after ten months. Large gap in abdominal wall with hernia at the end of twelve months. General condition too bad for operation to reconstitute the abdominal wall at present.
(*h*) Patient has been in perfect health since the operation.	(*h*) Patient has suffered much pain and misery.

It ought to be more generally known that the mortality of operations for acute appendicitis increases rapidly with the delay. Operations carried out within twelve hours of the onset of an attack are not more risky than those undertaken in the quiescent period. Still, it is common for the surgeon to be asked to see patients for the first time about the third or fourth day, or even later, when abscess, peritonitis, or other serious complications have developed. Similarly, the mortality of rupture of the intestine is only 15 per cent. when an operation is undertaken within four hours, whereas it becomes 70 per cent. when the operation is delayed until after twelve hours.[1] Similarly, the mortality of perforated gastric ulcer when an operation is undertaken within twelve hours is only about 5 per cent., but as high as 60 per cent. when the operation is deferred until after twenty-four hours. The waste of time is almost as serious and even less excusable with chronic abdominal diseases such as cancer of the stomach or large bowel. For less than one-third of cases of cancer of the stomach when first seen by the surgeon is resection possible, and the result of procrastination is nearly as bad in cancer of the rectum.

Avoidance of Waste of Time at Operations.

Time is frequently wasted during operations. It is clear that in order to get good results the surgeon must do his operations well and thoroughly, but it is often forgotten that to get the best results he must also learn to do them quickly and without waste of time. On the other hand, he must never do shoddy work so that he may be quick. While always conscious of the time element, he must not keep one eye on the clock, but both eyes and all his faculties focussed on his task. His aim must be to get so skilful and familiar with his work that he becomes quick almost without knowing it.

It is obvious that the dangers of most operations increase with their duration. If an operation takes an hour when it can be just as well, or better, done in half that time, the disadvantage of the patient is serious. He has to

take much more anæsthetic, which obviously adds to the dangers and discomforts still inseparable from anæsthetics. Further, manipulations and exposures are increased and prolonged with marked increase of shock, of post-operative discomfort, and danger of complications. These points do not need to be laboured, for they are evident enough to everyone who has eyes to see. When an appendicectomy takes only ten minutes the patient is hardly ill or uncomfortable in any way, whereas if it takes an hour he is miserable and sore for days.

But the value of smart work is much more striking in grave crises such as operations for acute intestinal obstruction or late peritonitis. It is no exaggeration to say that in these cases the mortality multiplies with the time consumed at the operation. The following case illustrates the value of quick work.

Acute Intestinal Obstruction by a Band: Appendix Adherent to Caseous Mesenteric Gland.—A boy, aged 6 years, was seized with very violent pain in the abdomen on the morning of April 10th, 1911. His father gave him two large doses of castor oil, which failed to have the desired effect. He was admitted into Guy's Hospital with a subnormal temperature, blue, cold, and pulseless. The abdomen was considerably distended, but flaccid. It was full in the flanks, and there was a palpable swelling in the right iliac region. On admission at 8 a.m. he was too bad for operation, and was, therefore, infused into the axillæ.

Operation.—The patient was given ether, and the abdomen was opened at 9.30 a.m. The lower part of the right rectus was displaced inwards. The peritoneum seemed to be purplish and clearly contained blood. It was opened, and a large amount of sanious fluid escaped, showing that the condition was one of intestinal obstruction and not appendicitis. Dark purplish, but not gangrenous, coils of small intestine were at once seen. Several coils were withdrawn, and a band was seen consisting of the appendix adherent to a caseous mesenteric gland. This was astride the lower end of the ileum, close to the cæcum, and completely obstructed it. The adhesion to the tip of the appendix was divided, and the empty cæcum drawn away from its former position, which was unusually high. The abdomen was then closed with through-and-through salmon-gut sutures. The operation lasted for seven minutes (the patient was only in the theatre ten minutes). He was not much worse at the end of the operation, but the infusion which was carried on throughout the operation was continued. Pituitary extract was injected in 5 minim doses. The patient rapidly recovered.

Our forefathers, before the introduction of anæsthetics, had no doubt about the value of rapid operating, but later a mischievous belief became common that, with anæsthesia, time did not matter. Unfortunately, there are still too many who appear to share this opinion. They waste valuable time—which belongs more to their patients than to them—in many different ways. It may be profitable to consider how to avoid some of this serious waste of time.

1. *By Making all possible Preparations and Calculations Beforehand.*—The skin is always prepared before the patient comes to the operation table. All necessary instruments, ligatures, and sutures threaded on needles are ready for use before the patient is completely under the anæsthetic. The surgeon and his assistant are quite ready to begin as soon as the patient is satisfactorily under the anæsthetic. The surgeon thinks out the various steps of the operation beforehand as far as this is possible. He makes up his mind quickly what he wants to do, and does it without unnecessary delay.

2. *By Improving and Simplifying the Technique of the Operation in Every Possible Way.*—Here a sound knowledge of anatomy and surgery and constant practice are essential. As regards the knowledge of anatomy and surgery, it is assumed that the surgeon will not undertake an operation unless he is familiar with the anatomy of the part and the details of technique of the operation which he contemplates. It is clear from the results of some of the operations for hernia recently undertaken that the operators were not familiar with the anatomy of the inguinal canal, for several cases have come to my notice of recurrence within a few months owing to the inguinal canal never having been opened. It is true enough that a surgeon has to get practice to learn, but a sound knowledge of anatomy and surgery, together with diligent practice on the dead body, will carry the beginner far. Everyone who wants to become a good and quick operator should practise on cloth all varieties of knots and sutures. In this way he will become expert and competent in a short time. It is often painful to see a man hesitating about his knots, and uncertain about his

method of sewing. Many men waste time by making the skin wounds too small, and thus allowing themselves only an unsatisfactory view of the parts. As a rule, except on the exposed parts, such as the face, there is no object in making a small skin wound. Much time is also wasted in blunt dissection instead of clean cutting. Both of these faults not only waste time, but add to the shock and local damage. Good hæmostasis saves much time. For instance, in most operations on the limbs a tourniquet is used, so that no bleeding occurs to obscure the view and delay the work. In other operations the main artery to the part is temporarily clamped or tied. For instance, the carotid is often clamped while operating on the neck. In most operations the important vessels can be secured before they are divided. Complicated instruments are to be avoided, for they waste time. For instance, a needle holder has no advantage in the majority of operations, but adds to the number of movements necessary for a given result. It is, of course. an invaluable and necessary instrument when working in a pit like the bottom of the pelvis. In ordinary work the finger and thumb are much more accurate, adaptable, and infinitely quicker. If one were to judge by the instruments they use, it might be concluded that some surgeons enjoyed making operations as difficult and prolonged as possible. The same may be said of many complicated methods, which are rarely as efficient as simpler ones. Continuous sutures save much time, and they are more effective and hæmostatic than interrupted. In grave emergencies an excess of fine detail in sewing is often to be avoided; the sewing should fit the occasion. Lives may be lost through the waste of time involved by an over-refinement of technique.

3. *By Concentrating the Full Attention upon the Operation.*—This is not the time for considering and talking of other matters, nor even for explaining the various steps of the operation to the inquiring stranger. The latter must be content to watch until the operation is completed.

REFERENCE.

[1] *Lancet*, 1908, vol. ii., p. 1143.

Humours of Regimental Work.

THE life of a Regimental Medical Officer is considered to be a monotonous succession of sick parades and medical inspections. The work is certainly most uninteresting, but the men are too amusing. My chief regret is that I am not an artist, and am so unable to sketch various amusing incidents that happened while I was attached to a Reserve Battalion.

One morning I was inspecting a draft for the front, and came across an absolutely toothless, would-be warrior.

"Where are your teeth, my man?"

"In me pocket, sir."

I had expected this, and said, "Why keep them there; don't you ever use them?"

"Not when I'm eating, sir," was the immediate reply.

Another rough-looking gentleman had a mouth full of rotten teeth, but was very keen on going for draft leave prior to being sent out to France. He assured me that he could bite anything.

"Anything at all?" I enquired.

"Yus, and me wife if I catches her."

After various experiences of this kind I have come to the conclusion that it is practically useless trying to replace carious by false teeth for men of this, the navvy class. They hardly ever use them, generally carry them in their pockets, and are always breaking or losing them.

Another time I was weeding out the unfit, and I came across a miserable old fellow who hadn't done any parades for about a year. He stated that he was an "employed" man.

"What are your duties, my man?"

"I am sanitary inspector to the barracks, sir," was the very unexpected reply.

Thinking that he must be a most valuable person, I said, "Of what does your work consist?"

"I cleans out . . . in the barracks, sir."

Quite a useful, but not an indispensable person in view of his general condition.

Another chronic rheumatic, chronic bronchitic old fellow with a chest like a musical-box replied to my inquiries as to his condition at night.

"I spends the night awakin' and spittin', sir."

The condition of some of the huts at night with several of these old fellows about may well be imagined.

One day we were paraded for a medical inspection of the recruits by a very important, very senior officer. He spotted several very young-looking boys obviously under the age limit.

"Say 'Halt, who goes there?' my boy," and the boy obeyed the order in a very high-pitched voice.

"Sixteen and a half years old," said the very senior officer. "I can always tell a man's age by the tone of his voice."

He did this once or twice fairly correctly, and, becoming very confident, said, "I can nearly always tell the age to the very month."

Doubting this I showed him a further beardless recruit. Again he was ordered to say "Halt, who goes there?" and obeyed in a high falsetto.

"Seventeen and 9 months," said the officer. "How old are you, my man?"

"Thirty-three, sir!"

A last anecdote, and I must conclude. One of our men in billets, who had been getting into no end of trouble, deserted, leaving his clothes in the billets with the following invocation to the Deity written on a post card, and pinned to his tunic—

"Oh Lord above
Send down a dove
With wings as sharp as razors;
To cut the throats
Of the ugly goats
They call the Sergeant-Majors."

This and other troubles await his return in the orderly room.

Perhaps these few yarns will show that regimental work has its humorous as well as its monotonous side.

L. G. D.

Letters from Guy's Men on Active Service.

Rawal Pindi British General Hospital B,
Amara, D.,
I.E.F., c/o India Office,
March 6th, 1916.

Many thanks for yours of 24th January just in. I have been out here now six weeks; we came straight up country from Basrah, and are about 120 miles up the River Tigris at a spot called Amara, and our hospital is going strong. We are right on the banks of the Tigris and have a 500-bedded hospital, in one brick building, about 15 big mud huts and numerous tents; at the moment we have in about 350 cases, of whom not more than 120 are surgical. I actually look after six of the huts with about 140 cases in them, all medical, mostly dysentery, malaria, and rheumatism.

We, of course, only admit British troops; there are also two other hospitals for British troops, but ours is far and away the best, though we have only three nursing sisters at present, and say what one may, one cannot run a hospital efficiently without them. I have no sister at all to look after my six huts, though I believe some are coming from India or England. Our staff is eight medical officers, including the colonel, and three of them have been sent up to the front for temporary duty in anticipation of a rush, so we are rather short-handed. Davies-Colley hasn't had much operating yet, though we do plenty of hernias, varicoceles, etc.; Eccles is away at present up country, and I hope to go up next week.

Railways and roads are as yet unknown in this Godforsaken country, though a mud road is at present being constructed between here and Basrah, consequently the transport of troops and supplies is a terrible problem, the river being the only means of access; the river is narrow and very tortuous and has strong currents, and the river boats are all small and flat-bottomed and mostly very primitive; two or three go up and down daily. It takes sometimes as long as ten and even twelve days to get up to our present front line from Basrah.

You, of course, know that at present General Townsend is surrounded with his forces at Kut. We have recently had a splendid lot of reinforcements go up and we are hoping every day for the scrapping to start in order to relieve them; when they do we shall, no doubt, be very busy. The Turks are aided by Arabs. The Turks are clean fighters, but the Arabs are dirty dogs, and it is impossible to trust them; they will fight on whichever side they think are winning. Our Tommies don't give the Arabs any quarter. Here in Amara we are surrounded by Arab villages, and the bazaar is run almost entirely by them. Occasionally they snipe the camps at night, but are mostly friendly, and are strictly kept under hand, and are earning pots of money from the British for the work done locally.

We are able to buy large supplies of sheep and beef from them, sheep being very cheap; only about $2\frac{1}{2}$ rupees each, that is, 3s. 4d. Chickens are obtainable in any quantity at 6d. and 8d. each; eggs 8d. dozen; and fish of enormous size, up to 150 lbs., and very good eating at 1d. per lb., caught in the Tigris. The climate is quite pleasant at the moment, though getting hotter every week, and very soon the heat will be terrific. The flies are becoming an awful nuisance, and the mosquitoes are rapidly increasing, though we do not yet use our mosquito nets.

One cannot possibly compare this campaign with France, everything here is so primitive, the country is desperate country to fight in, so absolutely dead level, and no shelter of any sort, just bare desert and enormous swamps in places. The rainy season is just over and the floods have been awful, and have completely stopped manœuvres, and our Tommies have really been through hell on earth. They are, however, all in good spirit and quite confident that we are going to hide the Turks; but it seems we have a long way to go before Bagdad is reached.

I have been in the R.A.M.C. a year this week, and get my captaincy on signing on again for another year, which I shall, of course, do. No doubt you will have difficulty in getting men to run the hospital, and I suppose one will have to call in the aid of the opposite sex if the war is prolonged. Glad to hear you are getting plenty of operating. Mind you write by return, as letters are a God-send in this remote country.

A. SEABROOKE.

Annual Report (1915) of the Bacteriological Department.

The work of the Bacteriological Department during the first year in its new quarters has been signalised by a considerable rise in the cost per specimen, from 2s. per specimen in 1914 to 3s. 10½d. in 1915. This increased cost is attributable to the action of several factors, the existence of which is a direct result of the European War in addition to those inseparable from the upkeep of larger laboratories, and consequent larger staff of cleaners.

The first and most important is the enhanced cost of apparatus and materials needed for the upkeep of the Laboratory. These articles were almost wholly obtained from Germany, either directly or through middlemen, and the cessation of supplies sent up the prices as much in some instances as 500 per cent. A second factor was the removal of a large number of qualified and unqualified men from the wards and Out-Patient Department with a consequent drop in the number of specimens brought for examination. This factor very materially influenced costs, since a large number of specimens can be dealt with more economically than a small one. Thirdly, the addition of War bonuses (to meet the increased cost of living) to the wages of the Laboratory staff, amounting in all to £30 per annum. These factors will continue to exert a greater or lesser adverse influence upon the economical working of the Department until the termination of the War.

Another point arising from a consideration of "costs" is the basis upon which the estimate is made. Prior to 1915 the cost was based upon figures representing the expenditure upon raw materials, labour, light, gas, and water. No account was taken of honoraria for the qualified staff or of rent, rates, taxes, and steam heating. On a similar basis, the 5,620 specimens examined during 1915 would come out at about the same price per specimen as those examined in 1914, but on the broader basis, as shown in the accompanying cost sheet, the gross cost works out at 3s. 10½d. per specimen. Taking the average number of occupied beds at 560, the cost per bed amounts to £1 18s. 10¼d.

These costs would have been higher, but for two facts. In the first place, the Director of the Department, having been deprived of the assistance of qualified assistants, a saving of the £75, which would have been paid in honoraria, was effected by the hospital; and in the second place, by arrangement with the Deputy Director of Medical Services of the London District Command, under the authority of the Army Medical Department, 4,301 specimens from "Military Typhoids" from Military Hospitals in London were examined in the Department between April and December. The Army Authorities defrayed the cost of materials and labour involved in the investigations, with the result that a sum of £89 (£75 of which is shown on the accompanying cost sheet) has been paid over to the Hospital for electric current, gas, water, and what may be termed "bench room." This arrangement (which is still in existence) has been of great value to the Hospital, since it resulted in the "badging" of the Chief and Second Laboratory Assistants, and the retention of their services to the Hospital. The Chief Assistant is a married man, attested in Group 33, and the Second Assistant has been rejected on medical grounds.

Other War work has also been carried out in the form of assistance rendered to the Pathologist of No. 2 London General Hospital to the extent of examining some 250 specimens (including all his Wassermann tests) and preparing 41 vaccines. The Bacteriological work of the Queen Mary's Naval Hospital, the Coulter Hospital, and the Royal Flying Corps Hospital is also carried on in the Department by the Director, who acts as Honorary Bacteriologist to each of these institutions. No part of the cost of this work is borne by the Hospital. (Signed) J. W. EYRE.

18th April, 1916.

BACTERIOLOGICAL DEPARTMENT.

	£ s. d.	£ s. d.
Salaries—		
Bacteriologist	150 0 0	
Senior Assistant ... ... / Junior Assistant	15 0 0	
(Payments between January and May, 1915, to Messrs. Ryffel & Sampson).		165 0 0
Wages—		
1 Head Laboratory Assistant / 1 2nd " " / 1 3rd " " / 1 Boy ... ... / 1 Lady Typist ... ... / 3 Scrubbers	...	... 336 12 4
Material and Upkeep of Equipment ...		... 314 11 8
Cleaning (Materials)		... 25 1 6
Heating		... 100 0 0
Gas		... 20 16 4
Water		... 18 1 3
Current (Light and Motors)		... 44 17 11
Repairs		... — — —
Rates and Taxes, taken at 8/- in the £ on the rateable value (£90)		... 36 0 0
Rent, 5 per cent. on capital outlay (£3,500), excluding site)		... 175 0 0
		1,236 1 0
Less payment from Medical School, £75 / " payment from War Office ... £75		150 0 0
		£1,086 1 0

Gross Cost per specimen, £0 3 10½
Cost per occupied bed = 1 18 10¼

The Therapeutics of Distilled Water.

BY G. ARBOUR STEPHENS, M.D., B.S., B.Sc. (Lond).
Hon. Physician, Royal Cambrian Institution for the Deaf.

IN the *Dublin Journal of Medical Science* for May-June, 1902, Dr. Walter G. Smith wrote a very interesting and valuable article on "Dissociation and the Ionic Hypothesis as applied to Medicine." It is an article that can be read and re-read with great advantage, as it contains matters of fundamental importance. In it he says: "We may regard the whole organism as a cell-complex traversed by innumerable osmotic streams and counter-streams which reinforce or counteract each other in endless variation, and it is in virtue of this interchange that the cells of the body are able to preserve their integrity in the face of considerable changes in their environments."

He also says: "Distilled water which contains few ions acts as a protoplasmic poison on living cells in virtue of the osmotic differences between it and the cell contents."

Battelli and Stefanini have shown that (1) "osmotic phenomena are always produced by differences of surface tension"; (2) "the direction of the osmosis is that in which it tends to equalise the surface tension on each side of the separating membrane."

Zlobecke has shown that "the surface tension falls with rise of temperature."

The importance of this last statement cannot be over-estimated, for, naturally, with the rise of temperature in fevers this rapid osmotic flow allows of the necessary quick escape of the anti-bodies formed within the corpuscles.

In the *Practitioner* for September, 1910, I endeavoured to point out the part played by colloids in physiology and pathology, whereby a variation of the colloidal surroundings affects the life history of the blood Corpuscles. In the *Dublin Journal of Medical Science* for June, 1911, I pointed out that by adding boiled yeast to yeast the latter grew very rapidly.

Cells are composed of two parts, structure and function, which normally are in a suitable relationship, but if this relationship be disturbed either by too much structure or too much function the result is disease. This relationship is disturbed by surroundings which affect the surface tension of the cells.

Both structure and function are enzymic in action, so that one can say that all cells secrete at least two enzymes—(a) for repair or growth, (b) for functional and interactional processes.

Boiled yeast stimulates the growth of yeast, both as to cell multiplication and function; but if the yeast cells boiled were poor in function they would stimulate growth and not function.

In health, the hardy cells when finished with, *i.e.*, when dying or dead, act as a stimulus for the young or fresh cells. In acute inflammation the cells are stimulated *for a time* both as to structure and function, but if the time be unduly prolonged these new cells fail either as regards function or as regards structure.

We find this to be the case in subacute inflammation when function shows evidence of failure, a failure that becomes more marked as the inflammation becomes more chronic, until in cancer the excessive structural development is the sign by which the disease is readily recognised.

When a part of the body is constantly irritated and injured, the repairing process is markedly in evidence, with the result that the structural functions tend to become over-stimulated, and if this over-stimulation continues long enough the structural part of the cells over-balances the functional, and cancer cells are the result.

A cancer cell is one where most of the energy is devoted to growth and very little to function; whilst in fever, on the other hand, function is stimulated at the expense of structure.

In an organ, if the function of the cells is diminished, the dead and dying cells stimulate the growth of the structural part of the cells, *e.g.*, in cancer of the stomach HCl. and pepsin are diminished, the cells are less functional, and consequently more structural, so that when dying they stimulate the formation and over-formation of structural cells. A similar remark will apply to cancer of the breast where function has ceased.

In blood diseases we find exemplified the necessity of the combination of form and function. If function fails, as indicated by a diminution of the red cells, then over-development of structure shows itself with the white corpuscles, amongst which we find all varieties of immature forms. On the other hand, if function is in excess, we find a condition of polycythæmia.

When trying the effect of subcutaneous injections of distilled water in cancer I obtained some very interesting results. Suppurating cases that were overwhelming in their offensiveness, after three injections of 10 cc. lost all their horrid smell, but the progress of the disease was not arrested. From this it seems to me that there are two processes in these cancer cases, the one caused by a superimposed pyogenic organism, the other by a prolonged structural stimulation.

These results convinced me that in a disease like syphilis, where the inflammation is chronic or subchronic, but not permanent, the subcutaneous injection of distilled water ought to be curative, and the large number of cases I have treated, in addition to those I have published in the *Lancet* and *British Medical Journal*, afford ample proof of my contention.

The treatment is not specific, but naturalistic, in that it only helps nature to recover itself, and it does this by so altering the surface tension of the corpuscles as to allow of a more rapid osmosis of the

"antibodies," whereby they are mobilised the more readily for the battle against the toxins, whilst diapedesis is stimulated.

Being naturalistic, it follows that distilled water injected subcutaneously where it comes into rapid contact with the leucocytes ought to be of value in all subacute or chronic inflammations. This inference was borne upon me only very slowly, but when I realised its force I decided to try it in chronic rheumatism.

The first case was that of a young woman aged twenty-five, who, since she was seventeen, has become more and more crippled by rheumatism. Her knees are bent and fixed, likewise her hands and elbows, and the whole skin is "hide-bound." Medicine, including Christian science, has had no effect, and when the knees ulcerated and ached fearfully her condition was terrible. The ulcers refused to heal under any local treatment, so I gave her three injections of 10 cc. of distilled water, when the ulcers healed.

The second case was a married woman, aged thirty-six, whose wrists and ankles had been swollen and painful for fifteen months. When I decided to try distilled water injections she had not walked out for two months. The first injection so benefited her that she foolishly went out and walked one and a half miles, with the result that she was "thrown back," but after eight injections the swellings have all disappeared; a little weakness remained for a time, but this has disappeared.

The third case was really extraordinary. A man aged forty-one had been incapacitated from work for three years by syphilis and gonorrhœal rheumatism. When I first saw him he was in bed with the toes of both feet very swollen, and ulcers on the left shin. He could not walk. I gave him 10 cc. of distilled water subcutaneously, and when I called to see him on the fourth day to give him the second injection my patient had gone for a walk. On the eighth day his walk was still further increased, so that in order to be in time he ran part of the distance. Four weeks after the first injection he resumed work for the first time in three years.

Besides rheumatism and gonorrhœal rheumatic cases, subacute inflammations of glands have responded well to this treatment, as in the case of a man aged sixty-six who was suffering from inflamed bronchial glands, one of which suppurated into the left pleural cavity, whence the pus was let out by operation. After the operation the patient was better, but a second gland seemed to be threatening the same process, so I decided to inject distilled water, and after four injections all symptoms have subsided.

I have also tried it in patients who suffer from periodic pain in the region of the appendix, and so far all the cases have greatly benefited, so much so that operations are not even thought of.

How often an acute attack supervening on a chronic disease has been the means of removing the latter. Is not this due to the increased osmosis produced by the rise of temperature?

So far I have found injections of distilled water of value in syphilis, rheumatism, gonorrhœal rheumatism, inflamed glands, and appendix cases, but it is quite possible to extend the list if a suitable case of subacute or chronic inflammation presents itself, and these notes are written in the hope that others will put to the test such a simple and harmless remedy, although a satisfactory one.

Appointments.

The following appointments commencing May 1st, 1916, have been made by the House Committee:—

House Surgeons.—A. D. Marston (Sir A. Fripp); K. L. Bates (Mr. Steward).

House Physicians.—J. E. Clarke (Dr. Fawcett); F. A. Knott (Dr. Beddard).

Out-Patient Officers.—P. G. McEvedy, I. R. R. Brogden, A. Tamour and H. Abdel-al.

Civil.

A. S. M. Palmer, M.D. Cantab., Medical Officer of the Convalescent Home, Worthing, has been appointed to the Kingston (Surrey) Union.

Royal Army Medical Corps.

Capt. A. S. Littlejohn to be Major.

R.A.M.C. (Territorial)

London Field Ambulance: Lieut. W. M. Langdon to be Captain.

South Wales Mounted Brigade Field Ambulance: S. Child to be Lieutenant.

Notice.

ENTRANCE SCHOLARSHIPS IN DENTAL MECHANICS.

APRIL, 1916.

Open Scholarship.—Mt. A. F. Bartle (£20).

Pupils' Scholarship.—Mr. R. S. Roche (£20).

Births.

MAY.—On April 12th, at the White House, Sonning Berks, to Dr. and Mrs. Norman May—a son.

FULLER.—On April 17th, at Milnthorpe, Westmoreland, the wife of W. A. Fuller, M.R.C.S., L.R.C.P., of a son.

LLOYD.—On the 3rd inst., at St. Leonards-on-Sea, to the wife of F. G. Lloyd, Temporary Surgeon Royal Navy—a son.

Death.

BALL.—On April 10th, of wounds received on the 9th inst., Lieut. Malcolm Ball, R.A.M.C., dearly beloved husband of Irene Ball, Emsworth, Hants., and fourth son of Mr. and Mrs. Ball, Lewisham Hill, Blackheath, S.E.

F. A. K.

GUY'S HOSPITAL GAZETTE.

VOL. XXX., No. 727.] MAY 20, 1916. [SIXPENCE.

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Passim.

AT the end of the war, when we have the complete recruiting returns open to inspection, it is safe to prophecy that the high percentage of men rejected as unfit and the large number who have broken down during the course of their training will draw much attention to the extent and efficiency of the medical care received by school children all over the country. Undoubted great progress and improvement has been made in recent years, but quite as certainly there still remains much to be done. Great energy is expended on observing and recording every ailment, large or small, and the numerous cards and forms encountered bear ready witness to the work, but though these form the basis of hugh masses of probably interesting statistics, we still read in the Board of Education's annual report that not more than half the children suffering from remedial though severe defects are cured of them during their school life. Also one learns from most big towns that many of these defective children have had no treatment, and for the very good reason that no treatment is available! The school doctor is clearly bound to be content as a mere diagnostician and rely upon the local possibilities for the great majority of the necessary treatments. Surely the organisation of existing and the creating of new remedial agencies is a most obvious field for the expenditure of more public funds than are spared at present. The knowledge of the existence of these defects, their number and their incidence and cause are all brought out so clearly in expensive reports that it seems unbelievable that more time and money are not spent on the needful organisation which the statistics so obviously suggest. Probably, like many other things, it will all be put right after the war.

DOUBTLESS everyone in his own particular way will feel some slight effect of the Daylight Saving Bill when it comes into operation on May 21st, but after all the only actual result of calling two o'clock three o'clock will be that we shall have an hour's more daylight when the day's work is done. It will hardly be as surprising as a sudden awakening in the land of the midnight sun, and our only real sympathy goes out in their shortcomings to those whose turn it is to "week end," or to the unfortunate who forgets that his watch has not made up the hour on its own during the night. Otherwise we picture a sleepy, somewhat distrustful feeling for the first few mornings and a vague sense of "being had," perhaps not for the first time.

IT is always gratifying to read an appreciation of medical work written in the lay papers, and the recent remarks of a special correspondent in the *Times* apropos of the extent of services rendered by the R.A.M.C. to the civilian sick in those parts of Belgium and France occupied by our armies form a welcome paragraph.

It is well known how unwilling are many of the general peasantry to leave their homes however near the danger zone, and the natural result is that casualties necessarily occur. The only aid available for these people is through the doctors of the R.A.M.C., whose services are many times asked and never refused. A great number of instances are mentioned where the need has been merely treatment of wounds, but it is pointed out that much work has been done in the prevention of epidemic disease, and even in the practice of midwifery, for which in many parts, owing to the absence of local doctors and forbidden night travelling, there has been a frequent call.

OF late there has been a notable absence of news from Guy's men on the various fronts, and though the appeal has been made on more than one previous occasion, we must again venture to stimulate the descriptive powers of our friends. Formerly there have been many highly interesting letters from all parts, the great majority of which have been published, and we would apologize to the writers for making no personal acknowledgment. Our appreciation is not to be measured by our inactivity in this respect, and we would urgently appeal for news which not only keeps touch between home and abroad, but also between former companions, often, by now, in the opposite extremes of the British fields of activity.

IT seems likely that one of the serious mistakes of what some scathingly call the recruiting muddle may be remedied by the new Compulsion Bill. Formerly medical examination can hardly be said to have been either satisfactory or conclusive, since there were only very indefinite grades between the man fit to take his place in the trenches and the man unfit for anything at all, with the natural result that many sooner or later fail completely under the strain, while many were turned away while fully capable of doing work which would release a man of stronger physique.

The waste of material resource is obvious in both directions. In future every man rejected since the now famous August 14th must submit to re-examination, a measure whereby much wrong may be righted by nevertheless a deplorable waste of effort when it is considered that every case could have been decided upon in the first instance.

WE have been asked to call attention to a country holiday home for children of officers, the professional classes, and the clergy, to be opened on June 1st at Hillyers, Cookham Rise, Berks. It is felt that there is great need for a home to provide change of air, in happy and healthy surroundings, for delicate and convalescent children belonging to those classes which are the worst sufferers from present conditions caused by the war. Further information may be obtained at any time from Miss Harwood, 56, Campden Hill Court, W., or from the secretary, Miss Richardson, Hurley, Marlow.

THIS week we have to record the retirement of Miss Agnes Coulton from the post of Sister Out-Patients. All will regret her loss after nine years' excellent and devoted service, during which time her charm and popularity have brought her a legion of friends. We hear that her departure may be only temporary, and can assure her of the heartiest welcome should she choose to return.

WITH deep sorrow we hear of the death of Lieut. M. E. Ball of wounds received during the fighting in Mesopotamia. He held house appointments at Guy's in 1908–1909, and for a time was Editor of the "Hospital Gazette."

The use of the Tourniquet:

A Plea for its more Thorough Use in Peace and War.

[Letter to *The Lancet.*]

I believe that if the full value of the tourniquet were properly appreciated it would be far more commonly and thoroughly used, especially in dealing with the wounded who are already suffering from loss of blood. These patients are badly affected by further bleeding. Sir George Makins, with his large experience, makes this point very clear* : "The loss of blood which accompanies the receipt of the injury is often very considerable; and although it may not immediately endanger the patient's life seriously, or call for surgical intervention to prevent the recurrence, yet the resulting anæmia is often persistent for some time, and may heavily handicap the patient's chances should a secondary operation become necessary. It has, indeed, much surprised me to see patients die a few hours after an operation in which, although a considerable amount of blood has been lost during the procedure, yet the patient has left the table in sufficiently good condition for no great anxiety to have been felt regarding his ultimate recovery. I believe this to be a definite sequence of the primary loss of blood, and it is a moment to be fully considered should the question of the performance of any operation likely to entail loss of blood arise."

The risks of sepsis and other complications are also increased by hæmorrhage. For these reasons it is especially important for us to do all we possibly can to prevent further bleeding. How are we to do this? By adopting a plan which I have found very valuable for many years in civil practice.

(A) For all operations upon the limbs a tourniquet is used and is not removed until the dressings are firmly applied.

(B) For all other operations: (*a*) The main artery or arteries are temporarily clamped or tied at the beginning of the operation whenever possible. Failing this (*b*) the small vessels are clamped before instead of after division.

(A) 1. After the limb has been well raised for several minutes to diminish the amount of blood in it, a good flat tourniquet is very tightly applied over lint around the limb well above the field of operation. The tourniquet must be very tight and have a reliable catch, for an imperfectly applied tourniquet obstructs the veins but not the arteries, and therefore increases the congestion of the limb and may cause severe bleeding. When the tourniquet is applied only a few drops of blood should escape, and a perfectly clear field is obtained for accurate work. No sponging is required, more perfect work can be done and much manipulation and time saved, and soaking of the tissues with blood prevented. Spread of infection in the septic military cases now so prevalent is thus rendered far less likely. Foreign bodies, like fragments of shell, can be far more easily and quickly found. The large vessels and nerves are easily recognized and avoided. Any large vessel that has to be divided—a rare event except in amputations—is tied. Shock is almost eliminated, for there is no loss of blood, and manipulations are reduced to a minimum. Very little anæsthetic is required, for the time of the operation is much shortened and the conduction of painful impulses to the spinal cord is diminished by the tourniquet. 2. At this stage most surgeons remove the tourniquet so that they may see and tie the bleeding points, but this step is unnecessary and wasteful of both blood and time; moreover, it adds to the risk of spreading sepsis already existing. When the main work of the operation has been done all dead spaces are carefully obliterated by catgut sutures so that no bleeding or effusion may take place into these spaces. Then the wound is completely closed in all aseptic cases, but in septic cases the wound is not completely closed, a gap about an inch long being left for drainage, but no gauze or tube is inserted except when the wound is deep and it is impossible to obliterate the cavity. 3. The skin is painted with tincture of iodine and aseptic gauze is applied, and the limb is surrounded by a large amount of aseptic cotton-wool. Bandages are then firmly applied to exert elastic pressure at, above, and below the wound. Massive dressings must be used and the bandaging carefully done in order to exert the proper amount of pressure without causing pain. The bandaging must be completed before the tourniquet is removed, for the object is to exert the elastic pressure before the circulation is restored. On the principle of the Bramah press, a moderate amount of pressure serves to prevent bleeding into the wound if it is applied first, whereas an enormous pressure may be of no avail when a pool of blood has been allowed to form in the recesses of the wound. It may be remembered that in the Bramah press hydrostatic pressure is exerted through a small pipe at the bottom of a wide cylinder. The lifting power of the water in the cylinder is enormously greater than that in the feeding pipe. The same is true of the small arteries and the pool of blood in a wound when the dressing is not applied until the tourniquet has been removed. That this is not a mere theory is shown by the results. Rarely is there any appreciable bleeding and very rarely is there sufficient to soak through the dressings, and this is almost limited to extensive wounds requiring drainage. Even in these cases the loss of blood is comparatively trivial. It has been suggested that in the septic wounds of military practice this method adds to the danger of spreading sepsis. My experience is distinctly the other way. When the patient is returned to bed the limb is moderately elevated, for this diminishes pain and bleeding and prevents swelling of the terminal parts of the limb, which may otherwise be noticed as a result of firm bandaging. For clean cases I have used this method with the most satisfactory results for many years, having gradually put it to the test with more and more severe operations until at last I used it with the greatest confidence in cases of extensive resection of bone

*British Journal of Surgery, January, 1916.

for the correction of severe talipes. Later, being much impressed with the detrimental effect of the severe loss of blood involved in the operations for acute infective osteomyelitis and for sequestrotomy, and during this war, I have tentatively extended the method to the septic wounds now so common, and with very satisfactory results. Therefore I have every confidence in recommending it, and I believe its adoption may lead to the saving of many lives, and also promote the more rapid and perfect healing of wounds.

(B) 1. Every surgeon is familiar with the great value of preliminary ligation of the lingual arteries in resection of the tongue. Similarly for removal of glands in the neck Crile's method of temporary clamping of the main vessels at the root of the neck is of the greatest value, making extensive operations more easy, radical, and expeditious to the great advantage of the patient. The principle can be safely extended to the military surgery of these parts. In the abdomen preliminary clamping or ligation is an established and beneficent principle, as, for instance, in gastro-jejunostomy, partial gastrectomy, resection of the bowel for growth or injury, and operations on the kidney. By this method many abdominal operations which were regarded as impossible on account of bleeding have been made comparatively easy and safe. 2. In many cases clamping and ligation of the main vessels being impossible, other methods have to be used. In these cases the individual vessels to be divided should be secured before instead of after division whenever possible.

R. P. ROWLANDS, M.S. Lond., F,R.C.S. Eng.,
Surgeon to Guy's Hospital: Capt. R.A.M.C. (T.
Queen Anne Street, W., May 6th, 1916.

The Dental Society.

At the General Annual Meeting of the above, hel on the 10th inst., the following prize-winners wer announced:—

P. Green and B. Eady to share the prize for the best paper read.

P. Green to the President's Special Prize for a Series of Four Papers.

The Casual Communication Prize was not awarded this year.

The following gentlemen were then elected to the following year's positions:—

President.—Held in abeyance during the Summer Session.

Vice-Presidents.—F. N. Doubleday, M.R.C.S., L.R.C.P. L.D.S. Eng.; E. B. Dowsett, M.R.C.S., L.R.C.P., L.D.S. Eng.; L. Bromley, M.A., M.B., M.C., F.R.C.S.; L. D. Wright, L.R.C.P., M.R.C.S., L.D.S. Eng.; F. B Bull, L.R.C.P., M.R.C.S., L.D.S. Eng.

Hon. Sec. and Treasurer.—J. Eskdale Fishburn.

Dental Correspondent.—H. Oliver Irwin.

Committee.—Messrs. Becker, Kingham, Jones, Goudge, Turner.

Ulcerative Stomatitis.

BY KENNETH GOADBY, L.R.C.P. LOND., M.R.C.S., D.P.H. CANTAB.

(Report to the Medical Research Committee.)

[With acknowledgments to *The Lancet.*]

Ulcerative stomatitis, often preceded by or accompanied with sore throat, is appearing sporadically among the troops in France as well as in some of the English camps. The disease is characterised by gradual onset of general malaise, red congested fauces, and acute inflammation of the gum margins; mastication and deglutition are painful, the cervical lymphatic glands are enlarged, and the tongue is furred and the breath fœtid. So pronounced is the last-named symptom that the term "fœtid stomatitis" is often applied to the disease. In the course of two or three days the inflamed gum edges become necrotic and a white false membrane may develop on the throat (Vincent's angina); the removal of this membrane leaves a raw bleeding surface. The necrotic process may spread to the cheeks, producing painful ulcers covered with a white tenacious membrane; the slough if removed with a swab or forceps leaves a raw, bleeding, acutely painful surface. The disease rarely progresses to perforation of the cheek or necrosis of the jaw in adults, but in children may be followed by deep sloughing of the mucous membrane and necrosis of the jaw. The sequestrum may include one or more of the permanent teeth. Rarely necrosis of the alveolar plate of bone occurs in adults, the teeth becoming loose and finally exfoliating.

The constitutional symptoms may be a severe chill followed by a rise of temperature (102° F., 103° F. being not uncommon), and the patient feels acutely ill, often out of all proportion to the objective symptoms; he looks "toxic" with yellowish greasy skin and a curious reddish-yellow complexion, often persisting after the acute local symptoms have subsided. Occasionally, mainly in children, the temperature becomes subnormal, always a symptom of grave import. Diarrhœa may be present. The pulse is rapid and small, the urine is concentrated, and frontal headache is usually complained of. There is frequently severe "neuralgia" (visceral referred pain) referred to one or other of the "neuralgic areas" corresponding to the portion of the mouth affected.

A smear preparation made from the gums, cheeks, or throat, and stained by Giemsa's method shows innumerable bacteria of two morphological forms: (1) bacillus fusiformis, and (2) spirochætes. Both are Gram-negative. Stained by Leishman's stain or Giemsa the fusiform bacilli are seen to be diplobacilli 6–7μ in length, with pointed extremities; the thickened ends are in apposition with a small clear area between, somewhat resembling the sheath form of the bacillus diphtheriæ.

The organism is longer and larger than the diphtheria bacillus and is slightly curved; plasmolysis is common. The second or spirillum form closely resembles the spirillum of relapsing fever as seen in blood films; it is wavy in outline, irregular in form, and without the characteristic regular "screw" form seen in spirochæta pallida. Many of the organisms show unmistakable spiral form; the "turns" of the thread are but four to six in number, the ends may be pointed, but the organism is usually about the same diameter throughout; in hanging-drop preparations from the tissue it is not motile. These spirochætal forms are variously stated to be: (*a*) spirochætes and an entirely distinct species from the bacillus fusiformis (Muhlens and Hartmann,[1] Ellermann,[2] Leukowicz[3]); (*b*) a pleomorphic form of the bacillus fusiformis (Vincent,[4] Tunnicliffe,[5] &c.). Considerable divergence of opinion exists on this point, but as anaerobic bacteria are notoriously difficult to separate in pure culture, the question of mixed colonies may well prove a complicating factor. The organism is an obligatory anaerobe, and is also serophile.

Sections made of the gum tissue infected by the B. fusiformis show deep penetration by both the fusiformis bacillus and the thread or spirochætal form, the latter being found in the deeper parts of the tissue. There is little tissue reaction, and the smear preparations show practically no positive chemiotaxis, and very few, if any, polymorphonuclear leucocytes are found in the "membrane," which is composed of necrotic tissue—in fact, the whole character is a tissue necrosis. Generally a small number of Gram-positive diplococci (pneumococci) are to be found mixed with the other organisms; they are only found with difficulty microscopically, and are few compared with the enormous number of fusiformis bacilli and spirochætes; they are of importance in the production of secondary infection. The B. fusiformis is not peculiar to throat and mouth affections. It has been found as the chief organism present in gangrenous appendicitis (Ghon and Mucha[6] and Kaspar and Kern,[7] and Hyde[8] in eight cases out of 102 examined), in cerebral abscess (Dick[9], Ghon and Mucha[10]), in metastatic abscess of femur (Silberschmidt[11]), in hospital gangrene (Vincent, Coyon[12]), in abscess of lung and empyema (Dick[13]), in a hand infection (Peters[14]). It has been isolated from the blood in a case of severe mouth infection (Lawson and Moses,[15] Buron). I have myself isolated the organism from two compound comminuted fractures, one of the humerus, the other of the femur, due to gunshot wounds; from cases of bronchiectasis, and from necrotic ulceration of the large bowel

The outstanding clinical symptom of B. fusiformis infection is the characteristic evil smell typically associated with fœtid bronchitis and bronchiectasis. The pathogenicity of the B. fusiformis is affirmed by some and denied by others; thus Tunnicliffe, and Muhlens and Hartmann found that the injections of pure cultures into guinea-pigs and rabbits was only occasionally followed by a small abscess at the point of injection, but that no general symptoms and no characteristic necrosis of the skin took place. On the other hand, Leukowicz found toxæmia in laboratory animals, commencing 36 hours after injection, and he further states that injections of pure cultures into the gums of healthy children produced no effect. Many observers have induced local tissue necrosis and gangrene by inoculating animals with pus or triturated necrotic tissue containing B. fusiformis, yet pure cultures have rarely caused more than temporary local swelling. Veszpremi,[16] however, succeeded in raising the virulence of the organism by successive passages through rabbits; gangrene was not caused in the earlier animals of the series, a local abscess only being formed, but after the fourth or fifth passage tissue gangrene followed injection of cultures isolated from the previous animal of the series.

Several outbreaks of ulcerative stomatitis are recorded among troops on active service. Thus in the Philippines a large number of cases occurred among the United States troops, in the South African War many isolated cases were seen, and at Standerton an epidemic occurred among the sanitary corps,[17] which was at first thought to be scurvy. An epidemic among the Chinese Coolies in the Johannesburg mines was also reported by Walker in the *Johannesburg Medical Journal*, and frequent mild epidemics are common among the native prisoners in the gaols in India. There is some indication that the disease is most often seen in this country among underfed children. Dogs when fed upon putrid meat develop generalised inflammation of the gums (Harley), and it is possible that constant inhalation of air tainted with putrid carcases may have a predisposing effect. Guinea-pigs fed upon groats only, without green food, ultimately develop generalised scorbutic symptoms, but before hæmorrhages are noted the teeth become loose and nflammation of the gums and general loosening of the teeth take place, usually in three to four weeks; the gingival tissues may become ulcerated. In one series of 20 guinea-pigs, which I fed upon groats and water only, four developed gangrenous gums. The etiology of the disease in man is obscure. Pre-existing chronic disease of the soft tissues of the mouth, especially pyorrhœa alveolaris, is undoubtedly an etiological factor, but is not present in every case. Infection from other cases may be a possible cause, but so far there is no evidence to support the view.

Ulcerative stomatitis may follow tooth extraction in a limited number of cases, when chronic suppuration has pre-existed, as, for instance, an impacted third molar. I have also seen several cases following the injection of local anæsthetics for tooth extraction. In every case the anæsthetic used was novocaine, the action of the adrenalin together with the trauma lowering the vitality of the tissues sufficiently to allow the gangrenous process to develop.

None of the recent cases seen from France suggest scurvy in appearance, and the similarity of the Standerton outbreak, already referred to, with the conditions under which the cases had been living, are suggestive that putrefactive emanations, or more probably actual

contact with earth containing putrefactive material, may be an etiological factor.

TREATMENT.

The organisms found in such profusion in the disease are obligatory anaerobes and will only grow if the medium also contains a suitable proportion of normal serum, a biological factor suggesting the use of lotions containing peroxide of hydrogen. On the other hand, the necrotic tissue once formed presents an almost impervious barrier to the action of most antiseptics, and in practice hydrogen peroxide does not give the best results; further, simple lavage of the mouth is insufficient and actual swabbing of the affected areas is always necessary.

Dilute chromic acid relieves the pain and promotes the removal of the necrotic tissue best. It should be used warm, diluted 1 in 200 to 1 in 400, and applied to the affected areas with a swab of cotton-wool wound round a probe, frequent rinsings with the lotion being also employed. Immediately after the use of the chromic lotion the affected area should be painted with a mixture of 20 grains of chloretone to the ounce of equal parts glycerine and spirit. Cocaine, 10 grains, and salol, 30 grains to the ounce, may be used if chloretone is not available. Any loose sloughs should be gently removed with the swab if partially detached, but due care must be exercised, otherwise the raw surface left is more painful than before. Hot fomentations should be applied frequently to the exterior of the jaws; there is little or no danger of suppuration of the cervical lymphatics following their use, and the relief is considerable, especially if referred pain exists.

Potassium chlorate, 10 to 15 grains, with perchloride of iron and magnesium sulphate, should be given internally, and the diet should be restricted to fluids or semi-solids, great care being observed that the mouth is efficiently cleansed after each meal. This is best effected by irrigation with a Higginson's syringe. It is inadvisable to perform any tooth extraction until the necrotic process is in abeyance, otherwise there is risk of increasing the local disease as well as a possibility of recurrent or secondary hæmorrhage. In two out of four fatal cases secondary hæmorrhage was the cause of death, one being a case of trypanosomiasis; the other two fatal cases developed septic broncho-pneumonia, also following tooth extraction.

The disease commonly yields easily to the above treatment, but chronic inflammation may persist and degenerate into pyorrhœa alveolaris with final loss of all the teeth. The interdental bone and both alveolar plates may be so affected by the original acute necrotic process that much of the root of individual teeth is laid bare; such cases, if not carefully treated, recur and invariably degenerate into chronic suppuration with alveolar porosis.

Vaccine treatment is indicated in the chronic stages especially, and in those cases showing secondary pneumococcal infection. I have also employed vaccine therapy successfully in the acute stages, using the B. fusiformis; it is not usually possible to treat with an autogenous antigen of this organism, owing to its slow growth even under strict anaerobic conditions and other difficulties attendant on the cultivation of all anaerobes. The anæmia and toxæmia of the severe and moderately severe cases are often difficult to combat, may remain for several weeks and even months, and are liable to recurrence.

Iron and quinine, fresh air, plain food, and no alcohol are indicated. Vaccines should always be tried. For three or four months subsequent to the attack special attention to the gums and teeth is essential. Any source of irritation, such as accumulations of tartar, irregular fillings, and carious teeth, should have proper dental attention, and the patient should be instructed to carry out a careful dental toilet, daily irrigating the interdental spaces until the tissues have recovered their tone.

DIAGNOSIS.

As regards the diagnosis of the condition, few difficulties are to be met with.

Scurvy, the disease with which ulcerative stomatitis is usually confounded, presents hypertrophied gums often entirely covering the teeth; the swollen gums bleed easily when touched. I have not seen petechial or periosteal hæmorrhage in ulcerative stomatitis. The fœtor of the breath in the two diseases is similar.

Pyorrhœa alveolaris is a more chronic condition. The teeth may or may not be loose, pus is present, welling up from the gum margins on pressure, necrotic patches may occasionally occur, but there is never the same tissue necrosis of large areas. The gums in pyorrhœa alveolaris may be hypertrophied but not to the same extent as in scurvy, and as a general rule no pain exists and the disease is generally discovered accidentally.

Pneumococcal ulceration of the gums and mouth is rare, and is characterised by a curious irregular mammillate roughening of the affected parts with small depressed ulcerating patches, but without tissue necrosis.

Lymphatic leukæmia may be associated with hypertrophic gingivitis, but no ulceration; the hypertrophied tissue is firm and less liable to bleed than in scurvy.

The white necrotic gums, the pain, and above all the examination of smear preparations will at once settle the diagnosis. When the throat is affected, diphtheria is closely simulated, and the Klebs-Löffler bacillus may occur, associated with the B. fusiformis (Priestley).[18] Bacteriological diagnosis alone will determine this.

Harley Street, W.

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[10]Loc. cit.
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[12]Loc. cit.
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[14]Ibid., 1911, vol. viii., p. 455.
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Notes on Electrical Diagnosis and Treatment

From a Clinical Lecture by C. E. IREDELL.

In view of the extensive use of electricity in the treatment of the wounded, a few remarks on the conditions in which it is of service may be of some interest.

In muscle testing a large indifferent electrode is placed on the back or any other convenient situation and connected with one pole of the battery, which should be capable of producing the continuous or galvanic and the interrupted or Faradic current. It should also have a milliampère meter and a commutator or reversing switch disc electrode which should be covered with lint or chamois leather. Both electrodes are well moistened. The Faradic current is generally used first, and the muscle gently stroked with the testing electrode. The current is turned on sufficiently to produce a contraction which is most marked over the motor point, *i.e.*, where the nerve enters the muscle, and which continues as long as the electrode is held against the muscle. In testing with galvanism the electrode is held against the motor point, and when the current is turned on, if it is of the right strength, there is a sharp twitch. No contraction occurs while the current is flowing, but another twitch is seen when the current is broken. When the cathode is placed on the motor point and the current is turned on the contraction (K.C.C.) is greater than if the anode is placed on the muscle (A.C.C.). By means of the commutator the current can be changed from one to the other. In muscle testing the muscle and its nerve respond as a single organ and are considered together. If reaction of degeneration (or R.D.) is present the response to Faradism is abolished, but the response to galvanism remains. The polar reactions are, however, altered, and A.C.C. becomes equal to or greater than K.C.C., and, what is just as important, the contraction instead of being a brisk twitch becomes sluggish.

The presence or absence of the reaction of degeneration is particularly useful when there is any doubt as to whether paralysis is due to an upper or lower neuron lesion, as in the former it is always absent and always present in the latter. In the diagnosis between an hysterical paralysis and lower neuron lesion it may also be of great value, as it is always absent in functional paralyses. In the diagnosis of surgical conditions, however, it gives evidence which has a definite value though it is rarely conclusive.

As a general rule the presence of R.D. does not indicate that a nerve is divided, and in any injury to a nerve the first alteration in electrical reaction that takes place is the abolition of response to Faradism. In the case of recovery from paralysis, voluntary movement returns before contraction to Faradism, which therefore is of comparatively little diagnostic use in surgical lesions.

In testing with the continuous current one finds that more current is required to make a degenerated nerve muscle organ contract than is the case with the normal. By using this fact information that is of real value is often obtained.

If it is found that the amount of current necessary to produce a contraction is increasing the nerve is probably divided or so bound down by adhesions that it is unlikely to recover unless it is set free. On the other hand, if less current is required the case is doing very satisfactorily. Usually nerve injuries recover very slowly and require months of treatment. They not infrequently recover much more rapidly if adhesions to them are divided.

If the contraction is sluggish the prognosis is not so good as it is if the contraction is brisk, even if the amount of current necessary to elicit it is the same in the two otherwise similar cases.

These reactions are all qualitative rather than quantitative as there are several factors such as the resistance of the skin, inaccuracy of the milliampere meter, etc., which make quantitative work very difficult. Of recent years condenser discharges have been used, and as the capacity of a condenser can be measured accurately this method may be a very valuable one. It is found that a healthy muscle contracts when a small condenser is discharged through it. If the nerve is injured but is likely to recover a greater quantity of electricity is required, and when the outlook is bad a still larger amount is necessary. One way of discharging the condensers is by means of a Morse key, but if this is used a sharp tap produces a much more marked contraction than a sluggish one, and it is therefore essential always to work with a metronome reverser which works quite regularly. One difficulty that is found in all muscle-testing is that in order to make a degenerated muscle contract the current has often to be so strong as to make other healthy

muscles contract as well, and this masks the contraction which is being observed. I have generally found that this difficulty was accentuated in using condenser discharges, and up to the present I have found the ordinary methods of more practical value.

The chief conditions in which electrical treatment is useful, and which are commonly seen in hospitals for the wounded, are paralysis, adhesions in and stiffness of the joints, derangement of the circulation of the limb affected, and pain.

Any one or more of these conditions may be present in an injury to the arm or leg, whether it be a fracture, nerve injury, or septic wound. All these conditions are present to a slight degree in almost every wounded limb, and generally one of them is a marked feature. The earlier electrical treatment is started the less trouble do they give and the more quickly does the patient recover.

Injuries to nerves are very common, but it is surprising how seldom it is that a nerve is completely divided. When this happens it is rarely caused by a bullet but almost always by a piece of shell. The relationship of the musculo spiral nerve to the humerus makes it specially liable to injury owing to its resting on the humerus. As a rule if the musculo spiral is divided it is due to a fracture of the humerus rather than to the bullet itself. Quite apart from this it seems —like the external popliteal which is the corresponding nerve in the leg—to be very susceptible to injury of any kind, and in this connection it is interesting to remember that wrist and foot drop are very common in alcoholic and lead neuritis.

It is not quite clear why stiffness of the joints and derangement of the circulation should occur so frequently in limb injuries. When the nerves are damaged the interference with nutrition is partly the cause. In cases of injury to the spine it is well known that the feet must be supported or else foot drop will result with shortening of the tendo Achillis, which may subsequently have to be lengthened in order to enable the patient to walk again. As this contracture does not occur in the majority of diseases which require prolonged rest in bed, there can be no doubt that the contractures are due, in part at all events, to nervous injury. In cases of foot and wrist drop it is almost as important to keep them supported as it is in cases of spinal injury.

But stiff joints and cold extremities occur with fractures and septic wounds where no nerve injury is apparent, and to a far greater extent than can be explained by disuse alone.

The condition for which electrical treatment is most often given is paralysis. It is said that the Faradic current is useful even if the muscles involved do not respond to it. This may be true, but it is much better to make the muscles contract, and this can almost always be done with the galvanic current if reversals are used. One way to do this is to use a small electrode as when testing, and the muscles involved can be made to contract one after another. Other methods are te have a larger electrode which can be wrapped round the limb, or to put the arm or leg into an electric bath. Whichever method is used the current should be sufficient to produce contractions without causing pain. The bath has the advantage that the current is distributed evenly over the whole limb, and therefore it is practically impossible to get an electric burn, but it has the disadvantage that the healthy muscles contract more strongly than the injured, and an amount of current sufficient to produce contractions in the latter is sometimes more than the patient can stand with comfort. It is better tn such cases to use a smaller electrode.

Next in importance to the electrical treatment of paralysis is that of stiff joints. Massage and passive movements are necessary, but sometimes the stiffness is so marked, and the pain in having passive movements so great, that electrical treatment is a great help. It is often stated that ionisation with chlorine and iodine ions dissolves fibrous tissue, and there can be no doubt that it is very useful in this condition. Whether the beneficial effect is due to the ions driven in is not altogether clear. If ordinary tap water instead of a solution of sodium chloride or potassium iodide is used the treatment is called kathodal galvanism, and the results obtained are very similar. Considered electrically the body is a membrane containing salts in solution. Distilled water is a non-conductor of electricity, and therefore when a current flows into the body it does so by means of the ions in the tap water with which the electrodes are moistened, and therefore any electrical treatment is really a form of ionisation. Ionisation is usually understood to mean a form of treatment by which a drug can be driven into a diseased area, and so this area comes more under the influence of the drug than would have been the case had it been given by the mouth. Thus a rheumatic joint would be more likely to recover if salicylates were driven

into it than if they were given by the mouth. Lewis Jones, however, extended this idea, and called all the changes that are set up in the body by the passage of a current through it ionisation. There is no doubt that certain drugs can be driven into the body.

The skin can be anæsthetised by driving in cocaine. Iodine driven into the skin can be detected in the saliva a few minutes later, and if iodine is painted on the skin, if the kathode is placed over it the drug will be driven in, and the brown colour disappears. The fact that iodine appears in the saliva shows that it is soon carried away and reaches the general circulation. This raises the question whether the presence of a few iodine ions for a few minutes can have the remarkable effect on diseased joints that is often described.

When one considers that the body is already saturated with chlorine ions, it is by no means clear that the driving in of a few additional ions can have the remarkable effect on dissolving fibrous tissue; this is sometimes seen after ionisation. If in a case of osteo arthritis of the hands iodine be driven into one and quinine into the other, it is very difficult to detect that these drugs—which differ so widely in their properties—have different effects on the disease. If, in a similar case, ordinary tap water is used instead of solutions of drugs, the effects appear to be much the same.

It seems probable that the body consists, electrically, of a solid frame work with a solution of sodium chloride circulating through it. In electrical treatment part of the current is conveyed by the fluid and part along the solid structures, and in local conditions it is changes set up in the latter that are responsible for the improvement obtained. There is no doubt, however, that the opinion of electric therapists generally is that the drug, driven in, produces the beneficial effects, and while the matter is still undecided there can be no harm done if a drug is used. In stiffness of the hand, elbow, and ankle, it is more satisfactory to put them into a bath containing a solution of the drug to be driven in, as the current then flows in equally all over the joint, and there is no fear of producing a burn.

In the case of the knee and shoulder pads are applied and special care has to be taken that the bony points do not get burnt as the current tends to be more concentrated over them and frequently little pain is caused.

Not infrequently the most obvious result of a wound is that the hand or foot gets swollen, blue and cold. The same thing may be present in a stump after amputation. The best way of warming up the part and restoring the circulation is to put the part in an electric bath and make the muscles contract by means of reversals.

The best example of the use of electrical treatment in the relief of pain is in the condition known as trench feet. The pain is often acute and the tenderness is so marked that the lightest massage cannot be tolerated. In treating the patient a large indifferent electrode is placed on the back and the feet are put into a leg-bath which forms the anode. The relief of pain is marked and recovery is generally hastened.

One other condition in which electrical treatment may be used is in septic cases. As an example the following case may be quoted as one in which the treatment was particularly successful.

A patient who had been wounded in France and had lost the sight of both eyes, had had the outer part of his elbow joint shot away leaving a wide open wound 4in. by 2in. The hand was normal, but the wound was very septic in spite of having the arm kept in a bath containing Wright's solution daily, and other surgical treatment. The bath caused considerable pain, and he suffered so much at night that he had to have morphia regularly and the question of taking the arm off was under consideration. It was decided to try electrical treatment, and while he was having a bath of Wright's solution a pad was put on his back connected with the cathode and the anode was connected with the bath. The current was turned on gently and so little was used that he did not feel it.

In a few minutes the pain produced by the solution became less, and at the end of twenty minutes he was much relieved. This relief continued so that he was able to sleep better than he had done for some time. The treatment was continued daily, and in a few days the pain was so much better that the morphia was left off, the wound became clean and began to heal over. This treatment has been used in the case of sinuses of very old standing, and with ulcers, some of which have been of a year's duration. Frequently this treatment is very successful, and probably more will be heard of it in the future.

Chapel Report, 1915-16.

The Committee have to deplore the loss of the Chapel organist, Mr. Denis Browne, who was killed in the Dardanelles. During the short time he had acted as organist, he had given of his best both to the Chapel Services and to the Choral Society, and his place will not be easy to fill. The House Committee decided not to make a permanent appointment until the end of the war, and since September, 1914, Mr. Golden has been organist. He has now resigned owing to the fact that most of his work is in York, and he is obliged to make his home there.

We have also lost Mr. C. H. Wells, by his resignation, from the service of the Hospital. He was most helpful in his management of the finances of the Chapel, and the Committee wish to put on record their appreciation of his work. Mr. W. J. Curry has been authorised to sign cheques on the Chapel Fund Account.

The House Committee undertook to have the Chapel cleaned this year, but owing to the scarcity of labour the work has had to be postponed.

Special sermons were preached by Mr. Roseveare and Mr. Carrick in Advent. The Bishop of Southwark was, unfortunately, prevented by illness from preaching on Ash Wednesday. We were glad to see Mr. W. A. Dunn again, who kindly came at very short notice to fill his place. Bishop Hook and Canon Hough preached on the Thursdays in Lent, and the Bishop of Woolwich in Holy Week. Bishop Hook held a Confirmation Service in the Chapel in May, 1915.

The following Committee has been elected :—

Ex-officio.—The Superintendent, The Matron, The Acting and Assistant Chaplains.

Elected.—Sister Lorna, Sister Luke, Sister Lazarus (re-elected), Sister Mary, Sister Job, Sister Irene, Nurses Remni, Roscoe, Roussiano (re-elected), Cone, Mackworth, Brown, and Collier.

CHAPEL FUND ACCOUNT

For the Year ended December 31st, 1915.

Receipts.	£	s.	d.
Balance brought forward	23	19	4
Collections :—			
Chapel	58	16	7
Bright Ward	6	19	7
Boxes	2	13	6
	£92	9	0
Payments.			
Flowers, etc.	4	11	7
Books, Printing, Music, etc.	6	6	2
Furnishing and Sundry Expenses ...	6	6	5
Special Collections :—			
Maternity Samaritan Fund (2 years) ..	13	9	4
Belgian Hospital	1	16	11
Hospital Sunday Fund	5	3	8
South London Church Fund	6	6	4
Balance carried forward	48	8	7
	£92	9	0

Audited and found correct,
CHAS. H. WELLS.

Spinal Anæsthesia,

With Special Reference to the use of Novocaine.

By C. COLGATE HOLMAN, M.B., B.C. Camb., F.R.C.S. Eng.

[With acknowledgments to *The Lancet.*]

The employment of novocaine as an agent for inducing spinal anæsthesia has been advocated by Canny Ryall.[1] More recently two series of prostatectomies in which this drug was employed have been published by Page[2] and Mortimer[3] respectively. These two articles are of special interest, as the writer in each case is an anæsthetist and not a surgeon.

Prior to using novocaine I had used Barker's stovaine-glucose solution in some 30 cases. Experiments carried out by Le Brocq[4] led me to expect that in novocaine I should find a drug almost equal to stovaine in anæsthetic action and considerably less deleterious to the patient. Le Brocq, working with rabbits, found that if the toxicity of cocaine was taken as the standard unit, then the toxicity of stovaine was 0·625, of novocaine 0·490. Injection of a 10 per cent. solution of stovaine caused intense hyperæmia of the tissues followed by sloughing. After injection of a 10 per cent. solution of novocaine there was no swelling and no hyperæmia; the part appeared normal and remained so. The preparation used in this series of over 300 cases was a five per cent. solution of novocaine and mannitol. The dose employed for an adult varied from 6 cg. to 8 cg. of novocaine.

Technique.—The injection was in every case made with the patient lying on his side with knees drawn up and back rounded. Barker's syringe was used. Puncture was usually made in the second or third lumbar interspace in the mid-line. In the earlier cases 3 or 4 drachms of cerebro-spinal fluid were allowed to escape before the injection was made, in the later cases a few drops only. If anæsthesia did not reach a sufficiently high level in five minutes the table was tilted. Failure to withdraw cerebro-spinal fluid occurred twice in the last 200 cases; in one case the needle was too short. In some cases several attempts had to be made before success was obtained, and occasionally lateral puncture succeeded after median puncture had failed. It is useless to make an injection unless a flow of cerebro-spinal fluid is obtained. Tinge-

ing of the first drops by blood is of no importance, but if pure blood flows from the needle a fresh puncture should be made. A flow of pure blood occurred on a few occasions only, and in no case was it followed by any untoward symptoms. In nearly 4 per cent. of cases anæsthesia after a successful puncture was absent or insufficient. This was generally remedied by giving a second injection, and in no case did any ill-result follow. Probably by some error in technique the first dose had failed to reach the proper spot. The average duration of anæsthesia was about one hour. On four occasions a second injection was given at the end of periods varying from one to one and a half hours after the first. The second dose was half the amount of the first. Results were satisfactory. In most cases anæsthesia reached to about the level of the umbilicus; in a few cases as high as the second rib. On four occasions, after an operation had been started successfully under spinal anæsthesia, a general anæsthetic had to be given for a varying length of time.

Operations for which spinal anæsthesia was used.—In the majority of cases the site of the operation was below the level of the umbilicus—*e.g.*, for hernia, hæmorrhoids, and varicose veins. Anæsthesia in the case of the two latter was always perfect. In operating on varicose veins spinal anæsthesia is specially useful, as the patient can lie in any position convenient to the surgeon. Some of the hernias were very large, and silver filigrees were used. Patients frequently complain of a dragging sensation in the chest when the neck of the sac is being pulled upon, but this seldom amounts to more than a passing discomfort. There was one case of suprapubic prostatectomy, an old man, aged 77, who distinguished himself by walking to the lavatory two hours after the operation. He was none the worse for the venture. This patient received a dose of 7·5 cg. of novocaine, so that it seems somewhat unjust for a surgeon to blame the method because a man aged 68 dies a few hours after receiving a dose of 15 cg. for a similar operation.[5] As regards abdominal operations proper, there were eight cases of appendicectomy, in one of which chloroform had to be given for ten minutes, four cases of umbilical and one of ventral hernia, and one caes of intestinal obstruction.

Type of patient.—The majority of patients were males, and their ages varied between 14 and 77. One patient was a medical man who had a dread of general anæsthesia. He underwent an operation for piles under spinal anæsthesia and was pleased with the procedure. My impression is that the best type for spinal anæsthesia is the stout alcoholic patient who often takes general anæsthetics badly. The thin nervous subject frequently complains of feeling faint at the beginning of the operation and is more liable to complain of unpleasant sensations if the peritoneum be pulled upon.

Symptoms occurring during the operation.—Faintness, often accompanied by nausea or vomiting, is common during the first ten minutes. It is usually relieved by half an ounce of brandy or a hypodermic injection of strychnine. Vomiting while on the table was noted in 4 per cent. of cases. The series includes several cases of strangulated hernia, and on nearly every occasion the bowels acted on the table after the constriction had been relieved. Serious symptoms never occurred in patients under 50 years of age, but there was more than one case of alarming syncope in older subjects. The weak point of spinal anæsthesia is that one has to give a more or less fixed dose of a potent drug, and no allowance can be made beforehand for the idiosyncrasy of the patient. I agree with Canny Ryall[1] in thinking that serious symptoms are directly due to the poisonous action of the drug on the nervous centres. This action is best combated by hypodermic injection of strychnine, or, if this fails, by intravenous infusion of saline. I have not tried injecting strychnine into the spinal canal according to the method of Jonnesco, but the uniformly safe results claimed by this surgeon have not been obtained in this country. The matter under discussion is of so much importance that I will give notes of the more severe cases. No death occurred which could be directly attributed to the anæsthetic in the case of novocaine, but I am of the opinion that this drug is no safer than stovaine because its lower degree of toxicity is neutralised by the fact that a larger dose is required.

CASE 1.—A man, aged 70, who had recently had half his tongue removed for cancer, was admitted suffering from a strangulated inguinal hernia. An injection of 6 cg. stovaine was given in the lumbar region. During the operation he lost consciousness and his pulse could not be felt. An intravenous infusion of saline was given and he rallied temporarily, but died 12 hours later. It is generally agreed at the present day that this type of case should be operated on under local anæsthesia.

CASE 2.—A female, aged 55, was admitted suffering from a strangulated hernia. A hypodermic injection of morphine gr. 1/6 with hyoscine gr. 1/150 was administered and followed by a spinal injection of 5 cg. stovaine-glucose. Three minutes afterwards she became unconscious, with shallow respirations and feeble pulse.

She improved after injectio strychninæ hypodermica ɱ x, but did not recover consciousness until the operation was finished. There were no subsequent ill-effects.

CASE 3.—Male, aged 53. A thin, unhealthy-looking man who had suffered from a tape-worm for about a year. He was admitted on account of a small hernia of the linea alba situated above the umbilicus. He said this caused him much pain and that he suffered from vomiting and constipation, but it is questionable whether these symptoms had any connexion with the hernia. A dose of 8 cg. novocaine was injected, and anæsthesia rose to about the level of the hernia. Five minutes after the injection he became faint and vomited foul-smelling material, He became rapidly worse and lost consciousness. The pulse could not be felt. Injectio strychninæ hypodermica ɱ vij was given, followed by oxygen inhalations and a pint of saline intravenously. He rallied after the infusion and recovered consciousness in about ten minutes. An action of the bowels took place on the table. The operation was concluded without further trouble, and there were no after-effects.

CASE 4.—Male, aged 53. Operation for radical cure of inguinal hernia. Dose of novocaine 8 cg. Fifteen minutes from the start patient became faint and said he could not see. Pulse and respirations were very feeble. He improved after injectio strychninæ hypodermica ɱ x. There was no further trouble.

Similar cases occurring after stovaine are recorded by Barker,[6] Milward,[7] Owen Richards,[8] and Madden[9]; after tropacocaine by Morrison[10]; and after novocaine by Mortimer.[3] The occurrence of such cases is disappointing, because many patients who appear to be equally bad subjects take spinal anæsthesia without a bad symptom. One case in particular impressed me. The patient was a man aged 66 suffering from diabetic gangrene. He was stout, cyanosed, and dyspnœic. After being placed on the table he was scarcely able to move without help. An injection of 7·5 cg. of novocaine was given and amputation through the thigh performed without a single bad symptom. He died 36 hours later, but death did not appear to be in any way connected with the anæsthesia.

Serious symptoms seem to occur most often in old and enfeebled patients, especially in those suffering from intestinal obstruction of long standing. I should hesitate to use spinal anæsthesia in the case of patients suffering from shock following severe injuries, although some authorities recommend it. The best treatment seems to be immediate intravenous infusion of saline. My impression is that in the case of old or debilitated patients an injection of strychnine before going to the operating theatre is useful as a prophylactic. One elderly patient underwent two operations for large herniæ. On the first occasion operation took place on the day after admission and he became markedly faint. The second operation was done after he had had three weeks complete rest in bed and he showed no trace of faintness.

After effects. — Backache and retention of urine appear to be less common than after a general anæsthetic. Some authorities express a contrary opinion. Headache is often troublesome during the first 48 hours. In my first 98 cases, thinking that headache might be caused by increased tension of the cerebro-spinal fluid, I allowed 3 or 4 drachms of fluid to escape before making the injection. Headache occurred in varying degree in 42 per cent. of these cases. In the later cases I allowed only a few drops of fluid to escape. Headache followed in 21 per cent. It was usually slight and relieved by aspirin. The figures are not large enough to be of much value, but it is reasonable to suppose that if one is injecting about 1 c.c. of solution it is best not to allow more than that amount of fluid to escape. My attention was first directed to this point by several cases, occurring among the early ones, in which the patient was comfortable while in bed, but complained of headache, faintness, and giddiness for several days after getting up. I attributed these symptoms to disturbance in the tension of the cerebro-spinal fluid. An instructive case occurred amongst the earliest ones,, in which I employed stovaine. A man aged 44 was given 4 cg. of stovaine-glucose in order that some adhesions in his knee-joint might be broken down. He was kept in bed for 48 hours, and as he had no bad symptoms he was allowed to return home. He was re-admitted in a few days suffering from very severe headache and pain in the back of the neck. All symptoms cleared up completely after further rest in bed. A rise of temperature to over 100°F. occurred in a few cases, but this is not uncommon after general anæsthesia.

Permanent after-effects are very rare. I wrote to a large number of patients nine months after operation and only two made any complaint. One man who had undergone an operation for piles wrote that the operation was quite satisfactory, but that he had suffered terribly with his nerves since. The other said he suffered from aching pain in the back. None of the terrible sequelæ recorded by continental surgeons was observed.

In conclusion, I would emphasise the fact that spinal anæsthesia is a method which must be employed with scrupulous care and attention to detail. It is more suitable for use in hospitals where the nursing staff is familiar with the technique and after-treatment, than it is for

casual operations in private practice. Like many valuable operations it has sometimes obtained a bad reputation through improper performance. Whether novocaine has any special advantage over stovaine I am not prepared to say. Its lower toxicity is neutralised by the fact that a somewhat larger dose is required. That it is less irritant to the tissues is, I believe, generally admitted.

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1. Clinical Journal, July 7th, 1909. 2. The Lancet' May 15th, 1915. 3. Ibid., Oct. 23rd, 1915. 4. Brit. Med. Jour., 1909, i., 783. 5. Ibid., 1913, i., 333. 6. Ibid., 1908, ii., 453. 7. Ibid., 1910, i., 743. 8. Ibid., 1911, ii., 1646. 9. Ibid., 1912, ii., 345. 10. Ibid., 1913, i., 1305.

Guy's Hospital Nurses' League.

THE Guy's Hospital Past and Present Nurses' League held its Fourteenth Annual Meeting on May 5th in the Nurses' Home, and despite the absence of many members on war service and lack of travelling facilities, there was a very cheerful gathering.

The League was founded by Miss Swift, then Matron of the Hospital, with the following objects:—

(i.) To promote social and professional intercourse amongst past and present nurses.

(ii.) To provide for present nurses increased facilities for mental and physical recreation.

(iii.) To provide a register of those who have received their training as nurses at Guy's Hospital.

2. The League shall embrace the following sections — The Choral Society, the Lawn Tennis and Croquet Club, the Swimming Club, the Hockey Club, the Library, the Nurses' Register, the Nurses' Debating Society, the Nurses' Photographic Society, and any other sections which the Council may decide to form, including the Cottage at Honor Oak Park, with the delightful garden and tennis court and opportunities for week-end and breakfast and tea visits for day and night nurses.

The Cottage is a great boon to the nurses, and especially to those whose homes and friends are at any distance.

Before the meeting, the Eighth Annual Dinner was held in the Nurses' Dining Room, and, including the Present Sisters, about 100 members were present. The Home Sister had decorated the tables with fresh spring flowers, and, as one of the nursing papers remarked, "We think the members of the League must always wish that the purchasing power of a shilling was as satisfactory as is the four-course dinner provided at Guy's on this special occasion."

One entirely unconventional addition to the Hall was a high partition up to the ceiling hiding the new extension to the room in order to seat 40 more nurses, but the present inconvenience will be more than atoned for by the after comfort this will give at meal times, especially at breakfast. Guy's is continually adding to its departments and activities, and, of course, this means a larger nursing staff.

The Matron, Miss Haughton, presided at the Dinner, and was supported by Miss Swift, R.R.C., now Matron-in-Chief of the Joint War Committee, Miss Minnie Long, home from Egypt, Miss Margaret Fox, Miss Atkey, Miss Hoadley (of the Langham Street Nurses' Co-operation), Miss Chittock, Miss Burdett, Mrs. Poolman, and many other old friends, and also a good sprinkling of Army Sisters in their effective gray and scarlet. After dinner, coffee was served in the hall, and during the evening several of the Present Nurses gave delightful song and instrumental selections, which were exceedingly well received.

At eight o'clock, on the motion of Miss Swift, Miss Margaret Atkey was elected to the chair. Miss Atkey opened the meeting by congratulating Miss Swift on her dual honours as recipient of the Royal Red Cross and as a Lady of Grace of the Order of St. John of Jerusalem.

Miss Haughton, as Hon. Secretary of the League, presented the Report of the year's work. The war had greatly interfered with the activities of the various societies, and there had been no Lawn Tennis or Swimming Tournaments, though both the tennis court and bath had been used a great deal. There had been 1,575 short visits paid to the cottage for breakfast and tea, 300 more than last year, and 175 week-ends had been spent there. The proposed extension of the cottage was postponed owing to the war, but more bedrooms and another sitting-room will greatly add to its usefulness and be very welcome in due time.

As a Christmas remembrance the League had sent 160 small gifts—pincushions or needle books—with a card showing the Front Gates, and the motto, "Time flies, sunshine and shadows fall, Let it go by, Love is for ever over all," to the Guy's Nurses serving abroad and nearly all had been safely received and acknowledged. In fact, one packet had followed a nurse out to Malta and back again to Milbank. Miss Haughton reported over 200 Guy's nurses working in France, Flanders, Egypt, Salonica, some on the way to Mesopotamia, via Bombay, and Nurse Plant unfortunately interned in German East Africa. In military and private war hospitals at home about 150 Guy's nurses are employed. Honours for Guy's nurses others than those already mentioned for Miss Swift, are :—

Royal Red Cross, 1st Class.

Miss V. N. Kiddle, Civil Hospital Reserve.
Miss M. C. Corbishley, Q.A.I.M.N.S.
Miss C. M. Tait McKay, Matron 4th S. General Hospital, Plymouth.

Royal Red Cross, 2nd Class.

Miss M. J. L. Lyons, Q.A.I.M.N.S.R.

Mentioned in Despatches.

Miss H. Suart, Acting Matron, Q.A.I.M.N.S.
Miss G. Allen, Acting Matron, Q.A.I.M.N.S.
Miss E. C. Cheetham, Matron, Q.A.I.M.N.S.
Miss G. E. Custance, Q.A.I.M.N.S.R.
Miss M. J. L. Lyons, Q.A.I.M.N.S.R.
Mrs. E. F. Watkins, nee Haggis, Q.A.I.M.N.S.R.
Miss Evelyn Densham, Matron, Duchess of Westminster's Hospital, Le Torquet.

The Report recorded with regret the death of four of the League members since the last Annual Meeting, Miss E. Witherow, Miss Beatrice Cheesman, Miss Margaret Hill, a member of the Guy's Trained Nurses' Institution, and Miss Herrmann, well known and honoured as one time Sister of Mary and Clinical Wards.

In the absence of the Hon. Treasurer, Mrs. Cameron, Miss Haughton also presented the statement of accounts. The finances were in a satisfactory condition, and it was decided to apply the balance in hand to the printing of the new Nurses' Register. The annual subscription in the case of sisters and administrative staff had been reduced from 10s. 6d. to 5s., and for third-year nurses from 12s. to 10s. A donation of £5 5s. had been sent by the Council of the League to the Club started by Mrs. Robertson Eustace for Army nurses in Boulogne, as the Club had benefited so many Guy's nurses. There was always a kindly welcome and much appreciated hospitality in the shape of baths, tea, and newspapers, and of this the donation was a slight recognition.

The election of three Hon. Members of Council, Mrs. Charters Symonds, Mrs. Fagge, and Miss Webster, were confirmed, and it was announced that the House Committee of Guy's Hospital had appointed Mrs. Cameron, Mrs. Lauriston Shaw, and Miss Sheldon as their representatives for the ensuing year.

A special vote of thanks to Mrs. Fagge was carried with acclamation on her retirement as Hon. Treasurer, which position she has held since 1906, and to her great energy and personal interest in the League the present satisfactory financial position of affairs is due. The thanks of the members were also given to the retiring Hon. Members of Council, the Hon. Mrs. Molyneux and Lady Perry. Miss Smith, as the indefatigable clerk to the Hon. Sec. and Treasurer, was duly thanked for her services with much enthusiasm.

The Fourteenth Annual Meeting will certainly have historic interest from the fact that the actual establishment of the College of Nursing was announced, the College having been registered on March 27th, 1916. Miss Haughton begged all present to realize that it is a truly momentous incident in the history of nursing and upon each one lay the responsibility to make the College the success it *must be*. Both Miss Haughton and Miss Swift spoke on the subject and a few questions were asked, but as we hope at a later date that the GAZETTE will publish an article on the College we will not anticipate it by reporting the above-mentioned short speeches. With the invitation to the League Meeting a statement of great interest regarding the College had been sent to each member by Miss Haughton.

All League members should feel proud that a Present and Past Matron of Guy's and Sir Cooper Perry, the Superintendent, Honorary Secretary to the College of Nursing, have taken such a prominent part, in spite of their very busy lives, in organising and establishing this College. As Mr. Arthur Stanley has said, this College will stand for much to the nurse of the future, and its establishment at *this time* will ever be a memorial of all that the profession of nursing has been to the nations at war in the twentieth century, A.D.

THE GUY'S HOSPITAL NURSES' LEAGUE PHOTOGRAPHIC SOCIETY.

The Annual Exhibition and Competition of this Society is generally such a special part of the Annual League Meeting, it was most regretfully decided that again this year there could be no competition. The use of cameras is, in many places, forbidden, and there are other war-time difficulties. There were, however, two large screens hung with photographs taken by the nursing staff and friends, and some beautiful subjects sent by the Royal Photographic Society, and a number of stereoscopic photographs kindly lent by Sir Cooper and Lady Perry, taken by them on various holidays.

After the meeting some lantern slides were shown made from photographs taken by Sister Jentie Paterson before cameras were prohibited at the Front, which greatly interested the visitors.

The excellence of Miss Smith's photographs is very well known and readers of the GAZETTE may be glad to know that four carbon prints, 10 by 8, can be obtained, post free, from Matron's office, price 2s. 4d. each, made from Miss Smith's negatives: The Front Gates, Colonnade Steps, Clinical from the Park, and The Nurses' Home.

After the cost of printing has been defrayed the proceeds will be divided equally between the Nurses' Photographic Society, to provide a new enlarging lantern for the dark room, and the Countess of Bective's Fund for sending out parcels to English Prisoners of War in Germany.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIRS,—I take the liberty of sending to your very respectable direction some numbers of our Italian Review, "L'Ospedale Maggiorè," which is published from our General Hospital in Milano, and I shall be very pleased if you will consent to have it exchanged with your Medical Review.

Your Journal shall be greatly appreciated from all the readers of our Medical Library, which possess a rich collection of the most interesting medical publications.

Looking forward to your very kind reply and with best regards, believe me to be

The Librarian,
ARV. MARIO ROLLA,
Secretary.

Milano (Italy),
3rd May, 1916.

SIR,—There is a vacancy for one officer in the 4/3rd Home Counties Field Ambulance. The Unit is at present a draft-finding Unit, and the work might possibly appeal to some Guy's man who has not yet joined up.

May I ask you, as an old Guy's man, to be good enough to insert this letter in the Guy's GAZETTE. I should be glad to interview any candidate and give full particulars.—Yours faithfully,

G. W. C. HOLLIST,
Capt. R.A.M.C.
O/C 4/3rd H.C.F.A.

Surbiton,
3rd May, 1916.

SIR,—There can be few Guy's men who are not familiar with Mrs. Foskett, the old lady who for many years has sold fruit at the foot of the steps from London Bridge Station. All who know her will be sorry to learn that, as a result of the present price of fruit coupled with a shortage of customers, things are in a very bad way with her. Unless she can get some help she will have to give up her stall and retire, not, alas, into private life, but possibly into the workhouse.

We are trying to put her on her legs at any rate for one more summer; if she can start the season with three or four pounds worth of stock she reckons to be able to trade with it right through the autumn, and by then we hope that a home may be found for her in an almshouse.

My object in writing this letter is to ask whether any Guy's men, past or present, are disposed to lend a hand in so worthy an enterprise. Dr. Poulton has very kindly undertaken to receive any donations, and I can guarantee that any money that is subscribed will be most prudently dealt with.

One other thing: It would help the old lady a lot if the Hospital would patronize her stall. I can vouch for the excellence of her fruit.—I am, Sir, etc.,

C. S. WOODWARD,
Rector of St. Saviour's.

The Rectory,
Sumner Street,
Southwark, S.E.
15th May, 1916.

Guy's Hospital Employees' Social Club.

The First Annual Meeting of the Club was held in the Pathological Theatre on April 11th, Mr. Robbins in the chair.

The Report and Balance Sheet were read and adopted.

The meeting re-elected the Committee for the ensuing year.

A vote of thanks to the Chairman was proposed by Mr. Curry, who drew attention to the difficult year, the first of its existence, the Club had just passed through, the war having restricted its activities. Mr. Croucher, in seconding this vote of thanks, pointed how the Club could expand in the future when the war was over and normal conditions were resumed.

The Chairman briefly responded and the meeting terminated.

REPORT OF THE COMMITTEE FOR THE YEAR ENDING MARCH 31st, 1916.

The first year of any new enterprise is generally a difficult one, and more especially is this the case during the present troubled times. It is with some satisfaction, therefore, that the Committee look back upon the past twelve months and feel that, in spite of all, the club is safely launched upon what they hope will prove to be a long and useful career.

The club originated in an informal meeting held on March 1st, 1915, when it was decided to hold a Social Evening and Whist Drive on March 16th, open generally to the employees of the Hospital and Medical School. A good number attended, and a General Meeting was fixed for two days later, when the club was formally set on foot, and a Committee of seven was appointed to manage the club and draw up rules. The Committee appointed a chairman, Mr. Robbins, and Secretary, Mr. Beale, and, under the powers conferred by the General Meeting, co-opted two additional members, the full Committee consisting of Messrs. Beale, Beckwith, Chapman, Croucher, Robbins, Saltmarsh, Sutton, Turner, and Williamson. The rules drafted by the Committee were, with one slight addition, approved by the General Meeting of the Club on April 27th. The last Tuesday in the month was selected as the usual meeting night.

One change in the Committee has taken place during the year, Mr. Baker being appointed upon Mr. Sutton leaving to join the army.

Eight ordinary meetings of the club have been held, the majority taking the form of whist drives, which are very popular and enjoyable. A social evening, with games, on January 25th was well attended, but the visit to Kew Gardens on May 15th and the concert on October 26th did not attract such good attendances as were hoped for, though they were greatly appreciated by those who went. The average attendance of members has been about 30.

The finances of the club are satisfactory, a balance in hand of 16s. 9d. being shown. The Committee must, however, point out that a number of prizes at the whist drives have very generously been presented by individual members, a generosity upon which it is not right to rely. The club should be strong enough to be self-supporting, even now. With an increased membership much more might be done to make the meetings interesting and enjoyable, and the social fellowship which it is the object of the club to promote, and in this the Committee feels it has not been unsuccessful, might be widened until it embraced most if not all of those men whose working hours are spent within the walls of the hospital.

During the year the club has lost Messrs. Furlong and Winston, who have taken commissions in the army, Messrs. Sutton and Bishop, who have joined the forces, and Messrs. Fielding and Nash. Some of these gentlemen we hope to welcome back in due course.

The Committee desire to place on record their indebtedness to Dr. Laidlaw for his continued kindness in permitting the club to make use of the Pathological Theatre for its meetings. Without this kindly help the whole scheme of the club would have been endangered. The thanks of the club are also due to Mr. Chapman who has undertaken the catering arrangements and discharged them to the satisfaction of all.

Reviews, etc.

Diseases of the Nose and Throat, comprising affections of the Trachea and Œsophagus. By Sir St. Clair Thompson. Second Edition. (Messrs. Cassell & Co., Ltd.) Price 25s.

The new edition of this work retains the general design of the original publication, but the subject matter has been to some extent re-arranged, and several new and valuable additions have been made. In its new form, therefore, Sir St. Clair Thompson's book has lost none of its virtues and gained in efficiency. It is always difficult to avoid the charge of being tedious when dealing with such strictly technical matter, but in this case the easy fluency of the author's style has made his book eminently readable.

The broad tolerance and freedom from personal bias is one of the outstanding features of this book in which references have been chosen with great judgment, and which in spite of protestations to the contrary in the preface, is supplied with an ample bibliography.

This work must be invaluable to the medical man, be he in general practice or engaged in this particular branch. It is replete with practical advice of a very useful type, and on certain subjects carries a very great authority.

Among many useful sections, perhaps the most striking for completeness, conciseness, and excellence of treatment is that on Tuberculosis of the Upper Air Passages, which includes a comprehensive description of this large and difficult branch of laryngology and a very helpful summary of the treatment from the pen of a surgeon whose experience in this subject must be unsurpassed. The new inclusions consist of descriptions of all the modern developments of rhinolaryngology which have achieved an established success.

Of particular interest is the special stress laid on the intranasal operation for drainage of the frontal sinus. At a recent meeting of the Laryngological Section of the Royal Society of Medicine, the opinions of the members were violently divided on every point relating to the operative treatment of the condition of frontal sinusitis, and one notes with interest the writer's preference for the intranasal route in the majority of cases, this being in direct opposition to Mr. Stuart Lowe's expressed views that intranasal interference must be completed by an ogston operation as a routine.

A further point of interest is the fact that more attention has been paid to direct methods of laryngeal examination (a new description of suspension laryngoscopy being included), and less importance is attached to mere virtuosity with the indirect method. The book contains a good index and many excellent illustrations.

Landon Out-Patient Tea Fund.

STATEMENT OF INCOME AND EXPENDITURE.
CHRISTMAS, 1915.

Income.	£	s.	d.
To Balance brought forward from last Account.—Cash at Bankers	29	7	2
„ Donations, Collections, &c.	53	18	0
	£83	5	2

Expenditure.	£	s.	d.
By Cost of Tea (Hospital Account)	8	9	0
„ Groceries, Provisions, Fruit, etc. ...	15	6	0
„ Clothing	20	0	5
„ Toys	28	4	1
„ Decorations	1	5	6
„ Printing, Stationery, etc.	2	9	4
„ Police Fees, Gratuities, etc.	7	10	10
	£83	5	2

Audited and found correct.
W. J. CURRY,
March 28th, 1916. Corporate Accountant.

Change of Address.

Lieut. A. Neville Cox, R.A.M.C., to No. 7 General Hospital, B.E.F.

Dr. T. F. Ricketts, from Joyce Green Hospital, Dartford, Kent, to Park Hospital, Lewisham, S.E.

Lieut. H. Mather, R.A.M.C., from No. 2 Camp Sling, Salisbury, to No. 2 Camp Sling, Bulford.

Dr. David Thomson, from 6, Avondal Road, Gorleston-on-Sea, to 207, Lowestoft Road, Gorleston-on-Sea.

Lieut. G. T. Foster-Smith, R.A.M.C., from 63, Shubra Road, Cairo, to 19th General Hospital, Alexandria.

Lieut. A. H. B. Kirkman, R.A.M.C., from c/o C. S. Chantley, Esq., "Bankside," Vernon Road, Leigh-on-Sea, to 14th General Hospital, B.E.F., France.

Birth.

TODD.—On May 5th, at 6, St. Thomas' Street, S.E., to Mr. and Mrs. Alan Todd, a son.

F. A. K.

GUY'S HOSPITAL GAZETTE.

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Passim.

WE hear of an important new clause which has been added to the Military Service Bill in the House of Lords. The clause enacts that there shall be established "professional committees to deal with claims for exemption made by duly qualified medical practitioners," and that such claims shall be referred to such a professional committee, whose decision shall be binding. It appears that the Central Medical War Committee and its local branches will form the recognised bodies thus outlined, and will find its position conveniently and enormously strengthened by this legislation.

Curiously enough, it appears that this clause is in no sense retrospective, and, as many total exemptions have been granted a few months ago to batchelor medical men who fall within the age limits, the probability is that as much discontent is likely to be caused in the profession as disturbed the public mind during the final working of the Group System among the laity.

The Committee has recently again circularised the profession explaining that the time for decision has now in actual fact arrived. It is explained how the breakdown of organised effort to distribute the profession by professional machinery is imminent and that if it breaks down, lay intervention is unavoidable. This is made all the more certain by the new Act, for medical men, equally with their fellow citizens, must either take service with the colours or secure their exemptions by holding up the best claims they can to criticism and review.

The prospect is in every way distressing, both to the individual and the profession. Still it most certainly seems that unless the Medical War Committee is put in a position to carry out its plan, this prospect will undoubtedly be realised. That position is only attained by obtaining the attestation of 75 per cent of available practitioners. From the recent activities of the Committee one would conclude that the goal is far from reached, and although it is not our purpose to favour or oppose compulsion, we would point out that unless the scheme of the Committee at once commands adhesion and the names at once appear either actually or in notified promise upon the roll, some rougher method is certain to be put into operation by the Government.

IT has come to our notice that during the last few weeks several practitioners have drawn attention to the unusual and serious increase in their districts of "non-notifiable diseases of a kind due to dust and generally prevalent in August." The classification or details of these maladies are not given, but it seems that with the motor bus wandering ever further and more frequently from home and the Borough Councils curtailing their expenditure on road repair, street watering, and general cleansing, there is a true lack of hygienic precautions and more than a possibility of inviting epidemic disease.

APPARENTLY we still find ourselves able to support those forms of street collections which consist of the sale of flags, badges, and other insignia by bevies of fair ladies posted at street corners, in fact, in some mysterious manner at all points of congestion, public or private. Every conceivable war charity or even peace time charity seems to have had its "day." On one recent "day" when a little yellow pasteboard lamp appeared in its thousands on the streets, three enterprises were connected with its sale—the Women's Service Bureau, the Women's Emergency Corps and the Star and Garter Fund, though probably not one in ten of those whose coats were decorated knew what any of the three organisations are or what they aim at. We prophesy that if this very excellent form of collecting is run to such an extent, there will be the usual public reaction against it, and it will assuredly be classified as a nuisance and its efficiency become extinct.

WE read in the annual statement of the Lambeth Infirmary of the great additional work that has been thrown on the Poor Law Infirmaries owing to the war. In number of patients there is an increase of 30 per cent.; the operations numbered 561, compared with 307 in the year previous to war, an increase mostly made up of major operations. In the pathological laboratory 2,190 specimens have been examined. It is an excellent record when there are so many other difficulties for such an institution to contend with.

AN innovation seems to have been provided by the activities of the Associated Physicians of Long Island, U.S.A. Drawing conclusions from the experiences of the European war, they suggest compulsory military training, a material increase in the standing army and navy, and the direct association of everyone of their members with some organisation active in matters of national defence.

Such proposals brought forward in any of our traditional societies would probably be regarded as out of place, and yet under war conditions we are beginning to see that the various departments of national life cannot be maintained in well-kept seclusion. Our present army is largely formed of men who, only a short while ago, never dreamed of being soldiers, and our R.A.M.C. consists mainly of men whose experience was limited to civil practice. The war over, it will not be so easy for these units to fall back into isolation and seclusion.

WE are glad to record that the Royal College of Physicians of Edinburgh has taken the action of offering diplomas of membership to Captain J. L. Lauder and his colleagues in the Wittenberg Camp. Everyone of us will be proud that Captain Lauder was a Guy's man, and most heartily approve of the College's action.

IT is with great regret that we hear the sad news of the death of Sir James Frederic Goodhart, Bart. Entering Guy's in 1864, he was appointed H.P. in 1869; Surgical Registrar, 1872; Medical Registrar, 1874, and became an Assistant Physician in 1877. In 1886 he was appointed Full Physician, which post he held until 1898 when he resigned office, and became a Consulting Physician to the Hospital. We hope to publish an appreciation of his life and work in our next issue.

WE are requested to publish the following important notice:—

THE COLLEGE.

Gentlemen bringing hand-bags and parcels into the College are requested to deposit them with the Porter, who will give a receipt and take charge of them until called for.

L. BROMLEY,
Warden.

June 1st, 1916.

Obituary.

MALCOLM EDWARD BALL,
Lieutenant, R.A.M.C.

Lieutenant Malcolm Edward Ball, R.A.M.C., was the fourth son of Edward Ball, J.P., and Mrs. Ball, of Lewisham Hill, London, S.E. Educated at the Roan School and New College, Margate, he entered Guy's Hospital as a student, and qualified M.R.C.S., L.R.C.P. in 1908, continuing a year later to M.B., B.S. London.

He held house appointments, ending with house-physician, and acted in the capacity of

editor of the GAZETTE. While at hospital he made many firm friends, and will be remembered by all of his time for his ability both in work and sports. Later on he married Evelyn Irene, daughter of the Rev. Dr. Ottley, Vicar of St. John the Baptist, Portland, and settled in practice at Emsworth, Hants.

Only last year in response to the urgent appeals of the British Medical Association he offered his services to the Royal Army Medical Corps and was given a commision in September. At Suvla Bay he contracted dysentery and was invalided to Malta. On recovery he was attached to the Worcester Regiment and proceeded to the Tigris front, where, on April 9th, 1916, he was severely wounded and died next day.

Lieutenant Ball leaves a widow and two children. A contemporary writes: "By the death of Malcolm Ball I and many others have lost a dear friend. Vigorous in mind and body he has always represented to me a charming combination of all the best qualities of a sportsman and a gentleman. To say that he will be deeply missed is but a poor way of expressing the blank sense of loss which his death has caused to those who knew and loved him."

Medical, Surgical, Obstetrical, and Therapeutical.

The Odour of Paint as a cause of Plumbism.

By H. H. MOYLE.

I BELIEVE few cases of this form of lead poisoning have been known and recorded, and I am somewhat reluctant to commit myself to the above title, yet being fully alive to the very great difficulty sometimes met in detecting the source of the poisoning I cannot but help feeling that the following cases are definitely due to the smell of paint only. The following is the history.

A man, his wife, and child occupied a cottage of two living and two bedrooms, all small, which early in October, 1915, was papered inside and thoroughly painted inside and outside, extending over about three weeks, the occupants living in the house as usual. The smell was commented upon at the time to one of the painters, eliciting the remark of "cheap tack and war time." At the end of November the man came to me complaining of vague pains in abdomen, nausea, and feeling of discomfort after food which at the time I treated for dyspepsia with bismuth, etc., with relief. Some days later I was called to see the wife, who was suffering from abdominal pains. On entering the house the smell of paint was most noticeable.

On examination of the woman nothing definite could be made out. Temperature and pulse normal, and she being of a somewhat neurotic temperament I decided that a little pain had been exaggerated and would be relieved if the bowels were opened. The same evening I was again called to see her. The abdominal pains were worse, and perhaps referred to region of gall-bladder more than another, yet they were more or less vague. No history of a previous jaundice, and the appendix had been removed about 18 months before. Temperature 99° F: pulse normal. Satisfied that there was no acute abdominal condition present I left haustus tr. opii ½ dr. for her. I saw the husband at same time, found he had not been so well and had stayed in bed.

On the following day the woman's pains were decidedly better. Temperature and pulse normal. On examination of her mouth the teeth and gums were in excellent condition except for three—viz., upper canine and two lower bicuspids. The gums opposite these showed a definite blue line. I immediately examined the man's mouth and found a well-marked blue line not only on the gums, but on cheeks and lips which came into contact with gum margin.

The cases presented the ordinary symptoms of lead poisoning, that of the man being more severe than the woman. Now as to source of poisoning. Occupation: The man does not come into contact with lead at all, while the woman in addition to her household work looks after railway crossing gates. Water supply: Examination negative as to lead. Other fluids: Wife teetotal, man teetotal except for occasional glass of cider. Food: Negative to direct contact. Fuel: Wood (unpainted) and coal. Usual china cups and plates, and nickel spoons, forks, etc.

As already remarked, the paint smelt very strongly and was rather sticky to the touch, even eight weeks after painting. I found the food had been kept in a small unventilated cupboard. With regard to actual contact with the paint by hands, this might occur in going upstairs to steady oneself (there being no hand-rail) by means of touching a wall and partition. Otherwise there was no reason to touch any painted surface, In the bedroom the bed was close up to the walls at foot, head, and one side. Two windows I have reason to believe were rarely opened.

In support of my title one knows that the illness caused by inhalation of paint odours is usually due to lead hydroxide acting on the oils and driers in the paint liberating deleterious aldehydes, and Murrell says: "Sleeping in a freshly painted room has been known to cause lead poisoning." I think that these two cases, living in a strong atmosphere of paint, and especially at night being so close to recently painted walls, certainly were the victims of plumbism from a rather unusual source. It seems, therefore, that a poor drying paint (? cheap), especially with deficient ventilation, may cause this illness, and more particularly amongst those who occupy small rooms, and are thus brought into more intimate contact.

Henstridge, Somerset,

Extract of the Dispensary and Pharmaceutical Laboratory Report for 1915.

The total number of Out-Patient attendances at the Dispensary during 1915 was 171,962 as compared with 176,973 in 1914; 188,238 in 1913; 197,557 in 1912; 220,591 in 1911; 221,847 in 1910.

These are classified for the last two years in the Table below, from which it will be seen that 84% of the Out-Patients paid the nominal sum of 3d. for their medicines as compared with 77% in the previous year.

NUMBER OF DISPENSARY ATTENDANCES.

1915.	Medical.	Surgical.	Casual.	Total.
Paying ...	61,575	35,998	48,180	145,753
Free ...	6,683	4,839	14,787	26,209
Total ...	68,258	40,837	62,967	171,962
1914.				
Paying ...	61,396	33,290	42,017	136,703
Free ...	11,850	6,843	21,577	40,270
Total ...	73,246	40,133	63,594	176,973

The Receipts have been as follows:—

	1915. £ s. d.	1914. £ s. d.
Out-Patients	1,820 10 9	1,720 1 0
Sale of Drugs	104 14 9	230 8 2
Net Profit on the Sale of Bottles to Out-Patients...	89 6 10	81 14 1
Goods supplied to the Medical School	88 3 6	118 10 7
Goods supplied to the Dental School	78 10 11	85 6 1
Goods supplied to the Institution	10 15 0	19 7 2
Medicines and Dressings supplied to the Nursing and Domestic Staff ...	38 12 7	67 19 10
Total	£2,230 14 4	£2,323 6 11

	1915. £ s. d.	1914. £ s. d.
Surgical Skiagraphic Dept.	7 17 0	10 0 11
Medical Skiagraphic Dept.	28 14 9	16 13 5
Works Dept....	10 7 5	7 17 0
Orthodpædic Workshop ...	26 19 5	14 11 1
Total ...	£73 18 7	£49 2 5

The cost of Drugs and Dressings during the last two years is given below.

	£ s. d.	£ s. d.
Drugs	3,790 3 3	3,986 5 8
Dressings	2,254 18 1	3,059 10 8
Total ...	£6,045 1 4	£7,045 16 4

ANÆSTHETICS.

	Quantity used. 1915	1914	Cost. 1915 £ s. d.	1914 £ s. d.
bsolute Alcohol ...	50 lbs.	100 lbs.	10 10 5	19 7 6
Chloroform	896 lbs.	778 lbs.	66 5 4	47 0 4
Cocaine and its Salts ...	9 ozs.	20 ozs.	5 9 0	4 16 6
Ether	2,198 lbs.	2,576 lbs.	190 0 2	210 8 3
Nitrous Oxide	68,000 gals.	40,600 gals.	111 7 6	118 8 9
Novocaine and its Salts ...	—	—	7 17 0	22 1 1
Stovaine	—	—	—	0 8 0
Quinine Urea Hydrochloride ...	—	—	—	0 13 8
Total ...			£391 9 5	£423 4 1

SERA.

	Cost. 1915. £ s. d.	1914. £ s. d.
Anti-Anthrax	4 3 4	4 1 8
„ Colon Bacillus ...	0 16 6	0 16 6
„ Diphtheria	48 14 0	43 6 0
„ Meningococcus ...	24 3 0	3 7 6
„ Pneumococcus ...	—	0 18 0
„ Tetanus	7 4 0	9 12 0
„ Thyreoidin	—	0 11 0
Normal Horse	2 8 0	2 12 0
Anti-Streptococcus ...	48 11 6	40 19 4
Total ...	£136 0 4	£106 4 0

(Signed) H. FINNEMORE, B.Sc., F.I.C.,
May 4th, 1916. Pharmacist to the Hospital.

Letters from Guy's Men on Active Service.

Rawal Pindi, B.,
B.J.H.,
Amarah,
I.E.FD.,
c/o India Office.
April 14th, 1916.

I found your welcome letter waiting at Amarah. I had been up at the front on temporary duty for the recent scrap in the effort to relieve Kut, and I picked it up on way down the river to Basrah in charge of a hospital ship and barge. At the moment I am writing this I am returning to Amarah from Basrah, going up the Tigris on an old Nile boat 35 years old, and this is her maiden trip up the river. I am S.M.O. (senior medical officer) on board, there being eight other M.O.'s on board and about 150 British and Indian R.A.M.C. personnel. We shall probably take four days to reach Amarah. We live on the deck, which hasn't even an awning over it, and the sun is terribly hot. We of course sleep under the stars. By the time I get back I will have been about 600 miles up and down the Tigris on this little expedition.

I went up in charge of a medical convoy party of one other M.O. and 18 orderlies, Indian and British. We disembarked at Orah, which was, previous to the fight, our most advanced position behind Kut. We had that day, however, advanced about eight miles up the river and taken two important positions, so the casualties were already pouring in. We could plainly see our guns at work; they gave the Turkish trenches a devil of a pounding at intervals all day long.

The first thing we did was to help load a hospital ship got 28 officers and 496 men on the ship with a barge alongside both her paddle boxes; she was packed. We then went on to dress the wounded, who were pouring down, being brought down the river from our new positions at Orah. I worked till 4 a.m. with a couple of Indians holding lamps, and these poor devils lying on the stretchers under the stars; fortunately it didn't rain. I then crept off for a few hours' sleep, as the next day I had to load a hospital barge with 60 stretcher cases, these being 60 very bad cases indeed, comprising 12 fractured femurs, 14 head cases, and lots of chest and abdominal cases. Having settled them up, we started to load at midnight the ship which I was to take down to the base; finished at 4 a.m., having got 90 more stretcher cases and about 30 walking cases on board. We then tied the hospital barge alongside us, and set off from Orah about 5.30 a.m., hoping to reach Amarah that night, about 130 miles; the river is so horribly narrow and tortuous that one never knows whether one won't stick for a day on a mud-bank. We, however, went splendidly. I urged the Captain to do his utmost to reach Amarah before dark, as really many of the cases on board couldn't possibly travel any further. I had, altogether, 22 compound fractured femurs and 23 head cases, and at least 20 belly and chest cases; many of the head cases being unconscious and very noisy and troublesome, amongst them two officers, both unconscious. I managed to get every case on board dressed by 7 p.m. (about 170 of them) and we reached Amarah at 7.30; by this time five cases were dead, and I dropped the forty worst cases at the Rawal Pindi and other British hospitals; I put off a couple of gas gangrenes which Davies-Colley operated on at once. I got my mails and had some dinner, and we moved off again to lay in mid-stream till daylight.

We left for Basrah as daybreak, and we had another strenuous day doing dressings. During the early hours of the following morning I had to open up an arm under C.H.Cl.$_3$ for gas gangrene (when we got to Basrah he had to have his arm amputated), surgery under difficulties without any question; no room to move, one had to do it in his cot with a case in the cot above him and cases all round one. We reached Basrah about 5 p.m. the following day, and with the exception of the five worst cases I unloaded them all direct into a fine hospital ship sailing for India the next day, and then waited for my orders to return, which I got 24 hours later and here I am. We, of course, are anxiously awaiting the news of the battle.

No worse place to fight in can be imagined, from the ships at Orah one looked right over the battle-fields, simply desert, not a tree of any sort in sight, only the Persian snow-capped mountains about 30 miles distant; we could see our artillery at work and our monitors and the æroplanes too, it was all very interesting, but how desperate to have to attack in such country and against such defences as the Turks have is ghastly; our Tommies are the finest fellows in the world. The Turks look decent fellows, fine big chaps, the prisoners I saw had no uniform at all; the Turks are openly defiant and very confident; we all pray that this battle may be decisive before the hot weather sets in, as though it is already grilling hot it is nothing to what it will be. I hope when I get back to my hospital that they will send me up to the Front again; it is such a relief from the monotonous life one leads in Amarah. I got time in Basrah to do some shopping and buy some goggles as the glare is terrible, another sun-helmet and a few delicacies for our mess, but the Arabs and Jews who trade there are swine, and must be making most terrific profits; they are friendly enough now, but still do a lot of sniping, more especially near the Front, and at night. I hope if we relieve Kut we shall have a real good Strafe of the Arabs when the fighting is over; the way they plunder, robbing the dead and wounded, and even digging them up, makes one so wild; they are, of course, quite uncivilised.
—Yours,

A. SEABROOKE.

Liver Abscess.

CLINICAL LECTURE BY CHARLES H. FAGGE, M.S., F.R.C.S.

GENTLEMEN,—The war has brought to our consideration a new aspect of many familiar conditions—a new aspect which has modified considerably our lines of treatment. It has also brought to our close inspection conditions which formerly were rare Physicians and surgeons who would properly treat their cases must do their best to become cognisant of all that has been written and done in connection with diseases which formerly were rarely seen, and which, owing to the war, may become common. The reason these conditions become common is that a large proportion of the male population of these Islands is travelling overseas east of the Mediterranean. Liver abscess due to dysentery, and practically always due to the amœbic form of that disease, has been exceedingly rare in connection with troops going to France. It has been comparatively common in connection with troops going beyond the Mediterranean. And the reason is, probably, that dysentery in the early cases was not treated actively.

During the past six months I have been called upon to deal with four cases of liver abscess. And about the same time we have had, in Addison ward, a man who presented a condition with which liver abscess may commonly be confused, namely, suppurating hydatid of the liver. You know that hydatid disease is not very uncommon in England, and I shall dismiss this case from further consideration by saying that I opened two large hydatid cysts, but I left one behind unopened: I did not realise it was there. The man died within a week, apparently of suppurative colangitis.

You will notice, perhaps, in the notes I shall read to you of four cases of liver abscess, that we were not at all prompt in making the diagnosis; and I want you to appreciate this thoroughly, because you will then realise the difficulties of diagnosis of liver abscess, and perhaps you will be alive to the possibility of obscure conditions of what one may call "hepatic pyrexia" being due to abscess of the liver.

Pte. W., æt 37, with 3¼ years' service, was taken ill with dysentery in Gallipoli on October 15th last. He had a little blood and mucus in his stools, and much abdominal pain. His bowels were being opened 12 or 13 times in 24 hours, and he lost two or three stone in weight. He was admitted to Hampstead Military Hospital on December 5th, when the bowels were opened three times a day. The diagnosis then was dysentery and bronchitis, and later there was added that of hepatitis. On December 27th, that is, three weeks after admission, he was not so well, and the note was impaired in the right lower axilla, and the breath sounds defective. The note also says "? râles at the right base behind." On January 5th the note is: Note impaired in right axilla to the 5th rib; quite dull in the lower part; friction fremitus in the lower axilla. Liver palpable one inch below the costal margin on the right; temperature normal, pulse 100. On January 7th his urine contained a trace of bile, the right dome of the diaphragm was pushed up and moved badly. I show you a skiagram of the man's chest, and you can see that the right dome of the diaphragm is higher than normal; this is what Mr. Shenton reported.

The medical officer in charge then—no doubt having read Rogers' Work on Dysentery—suspected that this patient had an attack of hepatitis. I may remind you that Rogers, who is the greatest authority on dysenteries and their complications, is strongly of opinion that there is a condition of non-suppurative hepatitis in dysentery which is amenable to the treatment by emetine. And he records cases in his book in which he suggests that some dysenteries hepatitis—as evidenced by a palpable liver, by jaundice, by some pyrexia, and by leucocytosis—may be cured, that the suppurative stage may be aborted by active treatment with emetine injections. So the M.O. gave this patient emetine on the 24th. Two weeks later we had a consultation, and there was no doubt, judging by the skiagram and by his continued ill-being without rise of temperature and with a pulse of about 100, that liver abscess was probable. In the 8th right intercostal space, in the mid-axillary line, a needle was introduced and pus drawn off. Four inches of the 8th rib was resected by the M.O., Dr. E. C. Taylor, the diaphragm incised and sutured to the intercostal muscles and pleura, and a director was passed along the needle into an abscess cavity. We got a pint of pus out and put in two drainage tubes. The operation took place on January 25th, and the wound was healed on the 12th of March. He is still in the Hospital, for recently his bowels have been opened four or five

times a day, and he is having half a grain of emetine night and morning. On one occasion, December 22nd, entamœbæ histolytica were found in the fæces. There were no entamœbæ in the abscess cavity or its wall, but they still occurred in his stools. On May 7th the note says that he had pain in his liver region, slight swelling and tenderness in the region of the operation scar, and during those days the temperature varied between 100° and 101°. I have seen him during the last week with the M.O. in charge, and he is certain now, as I think we all are, that, his temperature having fallen to normal, his condition of temporary pyrexia was due to his chest, not to any recrudescence of his abscess. I mention that because it is said that these abscesses recur; but, as in most other recurring conditions, it is really a residual process, something has been left behind. It seems that some of these liver abscesses which do extraordinarily well at first are allowed to heal too soon, owing to too rapid removal of the tube, and pus, etc., collects in the cavity.

The second patient was Pte. B., aged 51, who had had five years' service, and had been in India during that time. Otherwise he had not been out of England. He was admitted to Hampstead Military Hospital on the 21st of February; when on duty guarding the railway at Barnes, he went sick with influenza. He had had abdominal pain over the liver for some days previously.

On admission, there was great tenderness over the liver, corresponding to the gall-bladder. The liver dulness was increased, but the gall-bladder could not be felt. There was no history of colic.

On February 24th the temperature was 101°; on the 25th, 102°, rigor; 26th, rigor; 27th, 102°. On the 28th he was constipated; no spots. Spleen not palpable. Evidently the M.O. was thinking of typhoid. The movements of the right base were limited; breath sounds not heard over the right base.

On March 3rd I saw the patient, and the report says I regarded the condition as cholecystitis, and thought that operation was not immediately needed. On that date the liver dulness was diminished. On March 4th there was again dulness at the right base and absence of breath sounds. Temperature 100°. He continued in the same state until March 9th, when half a pint of cloudy straw-coloured fluid was withdrawn from his right base. The M.O. then pushed on the needle evidently penetrating the diaphragm, and reported that on passing the needle somewhat downwards and forwards blood-stained matter was withdraw. I operated on him the same day, excising four or five inches of the 8th rib behind the posterior axillary line. On opening the pleura, serous fluid came away; and after incising the diaphragm, and sewing the diaphragm to the thoracic parietes, so as to shut off the pleura, I opened a huge abscess cavity, and several pints of pus came away. No organisms were found in the fluid. Drainage tubes were inserted, but the patient died three days later. *Post-mortem*, there was found to be suppurative colangitis and a loculated liver abscess. There was an abscess in his lung, and some clear pleuritic effusion.

A common complication of abscesses on the right side of the liver is some infection at the base of the right lung. It is the old story of primary abdominal infection, secondary thoracic infection. The converse, in which the primary infection is in the chest, and the abdomen secondarily infected, is very rare.

The third case was that of Driver G., R.A., æt 22. He had four and a half years' service, and was in France in August, 1914. He was at Gallipoli from March to August, 1915, and he had some dysentery. He did not go sick with it, but was invalided home with fever and jaundice. He had been well until the 1st of May, when he was seized with upper abdominal pain. On the 2nd it was worse, and on the 3rd he reported the facts to his M.O. He walked into the hospital on May 4th, with a temperature of 100°, pulse 110, respirations 36. His abdomen was uniformly rigid, and the M.O. thought there was a slight fulness in the right epigastric region. I did not find this, but there was a point of excessive tenderness between the umbilicus and the xiphoid. The bowels had not been opened for two days. Saline was given into the axillæ, and he had two enemas without result. I think everyone was agreed it was an acute abdominal condition. I thought his trouble was secondary to appendicitis, and the M.O. in charge thought it was a perforated duodenal ulcer; if this were the case it was of that type in which the ulcer perforates into a local cavity, and gets shut off, and then ruptures into the general peritoneal cavity; these Moynihan called "subacute" perforations of stomach and duodenum. But he had not that urgent extreme abdominal discomfort which is so characteristic of the perforations of one of the large hollow

viscera into the general peritoneal cavity; there was not the same abdominal anxiety and agony. Obviously the right course was to open his abdomen. I did so, and found white fluid in the peritoneal cavity, but the appendix, duodenum and stomach were normal. The peritoneum was injected with lymph over the second part of the duodenum, and then I thought I had found the cause of his trouble. But I could not find a perforation there. On palpating the lower surface of the right lobe of the liver far back, I found a soft area about the size of an ordinary golf ball, and on pressing my finger against this pus came out. He had a liver abscess which had leaked into the general peritoneal cavity and caused general peritonitis. It was drained through the right loin. No organisms were found in the fluid. On May 10th the abdominal wound burst, and omentum protruded; and we had to shut it up again and put in drainage tubes. He is doing well, and he asked me this morning if he could have more food.

The fourth patient is L.-Corp. W., æt 30, who has been in the army twelve and a quarter years. When he came to us he had been ill for a week. He had pain on the right side. He was in hospital at Malta in October last, with a condition diagnosed as enteric. He had been at Gallipoli from June to October last year. He came to us on 19th April, when his skin was yellow, and he had a temperature of 100°, pulse 88, respirations 28. He was cyanosed and his breathing shallow. He had great pain over the liver, and was tender on the right side of the abdomen. One thought it was a case of pleurisy with the upper abdominal intercostal pain so commonly found in basal pleurisy. The blood count showed 11,630 leucocytes, and 8,000 of these were polymorphs. There was no bile in the urine. Pneumococci in considerable quantity were grown from his sputum. X-rays showed that his diaphragm was fixed on the right side. The liver was normal in size, and there was increasing dulness at the right base, extending in the mid-axillary line to the 7th rib. Breath sounds were diminished on that side, and the night temperature was usually 100°. There were no entamœba coli or e. histolytica in his fæces, nor was the bacillus of dysentery present.

At the end of April the man was so much better that he was out on the balcony, and the M.O.'s note says that the chest was clearing up. On May 1st he had no pyrexia. On May 3rd his diaphragm was observed to be moving only an inch on the right side, and the skin was more yellow. On May 5th his leucocytes numbered 16,600, and his temperature during several days varied from 100·6° to 101·6°. We had another consultation about the man, whom I regarded as a case of empyæma of the gall-bladder. The M.O. thought he might have a liver abscess, and we agreed that the right thing was to open his abdomen, and this was done. I found the gall-bladder and the liver normal. The liver was adherent to the diaphragm on the right side; I could not get my fingers between the diaphragm and the liver. Therefore I left my abdominal incision, packed it off, and put a needle through the right axilla so that it passed into the liver within the area adherent to the diaphragm and at once got pus. I sutured up the abdominal wound, and resected a piece of the 8th rib on the right side, and opened an abscess the size of a cricket ball, and drained it. There were no amœbæ in the pus. He was very collapsed after the operation, necessitating pituitary extract and saline, but the man has since done exceedingly well.

The original infection in all cases of liver abscess is intestinal; and while practically any intestinal type of ulceration may produce abscess in the liver, it is commonly met with only in certain intestinal lesions. It is pointed out by pathologists that bacillary dysentery rarely causes liver abscess, but amœbic dysentery commonly does so, the suggestion being that bacillary dysentery, apparently, causes an effect only on the mucous membrane and not on the submucous tissue.

Of the pathogenic entamœbæ which inhabit the intestinal tract, the best known is the entamœba histolytica, the other amœbæ, of which there are many, being of doubtful pathogenicity.

Of course, in the diagnosis of liver abscess, it is all-important to know that the patient does contain entamœbæ, and that is why, in all these cases the M.O.'s have been keen in examining the fæces for entamœbæ. And I told you earlier that these entamœbæ in the liver produce hepatitis, a pre-suppurative stage which Rogers treated with emetine. One fact of interest in connection with the cases I have quoted to you is, that there was no evidence, in any of them, that emetine had been given.

There is some difficulty in deciding how the liver becomes infected, *i.e.*, the path by which these entamœbæ reach the liver. You know well that in other infective conditions of the intestinal tract, such as appendicitis, ulceration of

the intestines or stomach, of all sorts, you may get an infection of the liver inducing multiple abscesses in it, via the portal vein and its tributaries, and that the condition of pylephlebitis leads to multiple abscesses of the liver; and it is possible that these dysenteric liver abscesses are so produced. But the difficulty in accepting this as the path — the difficulty chiefly in the mind of Rogers when writing of them — is that he insists that the morbid anatomy of liver abscess due to dysentery is that of one large abscess, not of many small abscesses. It is difficult to understand, if the infection was a venous one, and all the branches of the portal vein as they reach the liver contain these parasites, why the usual form of dysenteric liver abscess should be one large collection of pus, and not many smaller ones. So one must say that one does not know the path by which enamœbæ reach the liver and produce abscess.

It is easy to pass from this point to another difference in the clinical picture of liver abscess which I find in my small experience of four cases, as compared with that which Rogers paints, and in which he talks of a large abscess with a fibrous wall composed, apparently, of consolidated fibrotic liver tissue. In all the cases we have seen, the abscess wall has been simply ragged necrotic liver substance. And again, our findings have differed from his because he has insisted that in all his Indian cases it was comparatively easy to find entamœbæ in the abscess wall. All authorities agree that you do not find the organisms in the pus—the pus which is spoken of in the books as chocolate-coloured, or blood-stained. I do not think there is anything pathognomonic about this colour; it is mixed with blood because, I suppose, the liver substance bleeds easily after the pus has begun to come away. And our observers have not found organisms in the pus or in the scrapings of the abscess wall, in which Rogers records that he found the entamœba in something like 90 per cent. of the cases in which scrapings of the abscess were made. My expert advisers and teachers tell me that Rogers' findings in that particular have not been borne out by other well-known experts.

It is an interesting fact that the pus in these abscesses is at first sterile, and later, particularly in India, they become infected with coli and all forms of pyogenic organisms, and that this secondary infection with pyo-cocci is not an uncommon cause of death in liver abscess. I take it, therefore, that it is important to do all possible to prevent these secondary infections.

I now want to briefly consider other points connected with the ætiology of liver abscess. It is interesting to note that the survey of a very large number of cases showed that only 14 per cent. of single abscesses were in the left lobe, and when they do occur in the left lobe, they are very prone to extend and open into the surrounding viscera: the stomach or the colon.

Abscesses at the base of the right lung, or empyœmata, are common complications of abscesses of the right lobe.

The conception of dysenteric abscess of the liver which you have to get into your mind is that it is a subacute, single, right-lobed inflammatory swelling.

What are the common symptoms and physical signs of the abscess? Even Rogers says it is extraordinarily variable in its acuteness and course. The usual evidence of the subacute single abscess, remittent fever with a temperature of 100° to 103°, not continuous, sweats, wasting, loss of appetite, and very variable jaundice. You will have noticed that in none of the cases I have spoken about was there any marked degree of jaundice noticeable. One patient was "yellow," another was "sallow." And in connection with this, only twice was a note made that the liver was enlarged. Apparently if the liver does enlarge when there is a right-lobed abscess, it extends upwards, and not, to any extent, downwards, so that, as a rule, it is not palpable below the costal margin. Pain and tenderness on the right side, with inability to lie on the right side, were often met with, and signs at the right base. Rogers' and other books give pictures of huge abdominal swellings, which one would not conceive could have been due to pus, but apparently that was so; these form when the right lobe abscess is related to the anterior abdominal wall. When the abscess is, as is most common (40 per cent.), related to the thorax they are slower in producing clear evidence, and afford greater difficulties in diagnosis. Perhaps this is some consolation to us in having delayed the diagnosis of our cases.

If these patients are skiagraphed, the picture is of value on three points. The first is, as to whether the diaphragm is raised. In the case of Pte. W., you will remember, the diaphragm was raised on one side one inch above the right nipple. I have here of L.-Corp. W., Case 4, a skiagram in which the right diaphragm reached nearly to the base of the heart; the abscess in the right lobe pushed up the diaphragm. The second point shown by X-rays is that the dia-

phragm is immobilised. I do not think that is of great value in itself, for I imagine a diaphragmatic pleurisy would immobilise the diaphragm.

The third point is that the abscess appears as a definite localised area of increased density in the liver as seen with X-rays, but in none of the cases we skiagraphed was this seen.

Apparently the mortality, from an average of a number of recorded cases, is about 50 per cent.

I think you will already have gathered, from what I have said, what some of the conditions are from which liver abscess has to be excluded, *i.e.*, from suppurating hydatid, from suppurating pyle-phlebitis, from suppurative cholecystitis, from subphrenic abscess, and from infective conditions—these, perhaps, most difficult—above the diaphragm. But I do not think it matters much, in regard to the conditions I have specifically mentioned, whether you do differentiate between them, the main point being to determine that there is pus in that region, which you will naturally look for, either by an incision or with a needle. So, with very little advantage to you, I might talk for an hour about the differential diagnosis of these conditions, giving a number of data of a theoretical nature in favour of one and against the other. It seems to me that the right aspect of mind to cultivate is, that if one of these conditions is present, the sooner the pus is got rid of, the better. It is more difficult to exclude some non-suppurative condition like pleuritic effusion, or there might be an empyema, and again the value of an exploration with a needle would be great.

So it comes to this: that if, after the passage of a certain time, the patient does not improve and the signs at the right base do not pass off, you must explore, either with the knife or a needle. This was the line we took in all these cases, though in one case—not the fatal one—we delayed uncommonly long.

When operation can be undertaken, I think exploratory puncture should be done. Apparently there is some risk, chiefly, to my mind, theoretical, about putting a needle into the liver. The risk is one of hæmorrhage into the liver, into the abscess cavity, or into the peritoneum. You can adopt one of two routes, as you will have gleaned from my narration of these cases. You can either incise the abdomen and, if possible, find the abscess and drain through the abdomen; or incise the thorax and drain through the thoracic wall. A M.O. asked me, in regard the 4th case, "Why didn't you go through the chest first?" and I replied, "Because I was not satisfied with the accuracy of the diagnosis, and that he had not got something wrong with his gall-bladder." My original diagnosis was that he had suppurative cholecystitis due to gall-stones. But in that case I had afterwards to resect a rib and open the abscess through the thorax.

The incision into the abdomen is, like all abdominal incisions, placed at the best available spot, and the peritoneal cavity packed off. Most of the text-books dealing with the operation insist that the liver should be sutured to the parietal peritoneum before opening the abscess. In the first place, this is very difficult, and, in the second place, it does not provide adequate protection. A much better way is to rigorously, and, I was going to say, ceremoniously, pack off the suspected liver area from the adjacent viscera; then the risk of pus getting to the general peritoneal cavity is minimised to an unimportant level. It has got to be drained, and the rest of the wound must be closed.

There is an interesting article in Burghard's "Operative Surgery," by Sir Rickman Godlee, in which he gives two practical points. One is that the rib to be resected, when dealing with the abscess by the thoracic route, should be the highest possible, because the liver tends to retract upwards, and the higher the rib removed, the better the drainage. And the second point is that the pleura has got to be shut off. The best way is to open it freely, and then to incise freely the exposed diaphragmatic pleura and cut well into the muscular substance of the diaphragm itself. The margins of the incision, particularly above, of the diaphragmatic pleura can then be sutured to the parietal pleura and intercostal muscles.

If, as Godlee and other authors suggest, you first sew up the pleura and then incise the diaphragm, you are likely to cut the stitches with which you have sewn the pleura up, or may find your space too small, and then the pleural cavity will prove not to have been secured against invasion by pus. The pleura having been shut off, the abscess is drained.

Finally, I would mention that Rogers is of opinion that emetine is of the greatest value in the after-treatment of these patients, because he assumes that the walls of these abscesses contain the entamœbæ. So, in some of the

cases emetine has been applied to the abscess wall for the purpose of killing the organisms in its wall.

I have not referred you to two methods of dealing with these liver abscesses, which at the present day are rather historical than practical. One is Manson's method of putting in a trocar and draining the abscess through the tube. The other is Rogers' method of aspiration. After aspiration of some of these large abscesses with a trocar and cannula, a solution of quinine was irrigated into the cavity, and if any recollection took place, it was repeated. But it seems to me that those two methods are now out of date.

I would only add that if, and when, you have time to read what is interesting, as contrasted with what is of examination value, you will do well to read Rogers' book. I have not read, during the last year or two, anything with so much pleasure as I have read Rogers' "Dysenteries." Not only did I read that which concerns the clinical work of interest to myself, but I also read most of what is purely scientific and of no clinical interest at all—the history of dysenteries, of their gradual discovery by bacteriological methods, and of the facts connected with dysentery itself. I am sure you would very much appreciate the charm of the writing and the obvious enthusiasm of the author, for one of the most charming features which can attach to any book, is that the author is enthusiastic about his subject.

Change of Address.

Captain J. York Moore, R.A.M.C., Machine Gun School, A.P.O., S. 18, B.E.F.

Temporary Captain H. H. Elliot, Scraesdon Fort, Antony, near Plymouth.

2nd Lieutenant J. H. E. Winston, 5th Yorks Regiment, Hackney Wick Camp, Redcar, Yorks.

George Dee, L.D.S., 28, Broad Street, Ludlow,

Capt. F. E. Hutchinson, from Geelong Camp, Victoria, to A.M.C.—A.I.F., 1st Australian General Hospital, Egypt.

Dr. J. Birch Martin, Northend Place, Felstead, Chelmsford, Essex.

W. Beresford Robinson, Officers' Mess, 2nd London General Hospital, St. Marks College, Chelsea.

Albert H. B. Kirkman, 11th General Hospital, B.E.F., France.

E. G. Schlesinger, Temporary Surgeon, R.N., 1st Field Ambulance, Royal Naval Division, Eastern Mediterranean Squadron, c/o G.P.O. London.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—In your issue for January 15th you published a very interesting letter from the Hon. Arthur Stanley, dealing with the subject of organisation of the nursing profession, and opinions on the subject were invited.

I am so far away that any contribution of mine is bound to reach you late, but I should like to say just a word or two.

I am of opinion that the suggested College of Nurses, and Examining Board for granting diplomas in nursing, would be a splendid idea, and would do away with the abuses of the present system of certificates of proficiency given by different hospitals after varying periods of training.

At present a public examination must be taken by a nurse who wishes to do maternity work, or a Government appointment, but, as far as I know, this is the only branch of nursing where an examination is compulsory, and even it is only compulsory under the circumstances mentioned.

I have known of nurses at Guy's who have had three years' training without getting a proper proportion of the different branches of work. A head nurse told me once that she had applied twice for a change to a medical ward, as most of her training had been on the surgical side, and she wished to leave the hospital as well equipped as possible, but in each case her application was refused. If a system of public examination were instituted cases of this kind could not happen, as a definite curriculum would be enforced just as it is for medical students, and the hospital would sign up the candidates for work and appointments done.

I am sorry to say it of my own hospital, but I have known of cases where a nurse's training certificate, which may be said to make or mar her professional career, has been totally wrong. I admit that examinations are not ideal, and that it is not always the fools who get ploughed, or the good men who get through, but examinations are at least impartial, and a hospital certificate may be very misleading.

There were once two probationers in Clinical. One was exceedingly conscientious, and worked unceasingly to make her brass work shine, but all her elbow-grease and polish never seemed to produce a good result—at least it never satisfied either her or the ward sister. The other used to annex the hydrochloric acid from the Clinicals' room and her brasses were exemplary. On these principles they proceeded through their training, and the first one turned out a very good nurse and received a third class certificate on leaving, while the second left Guy's a thoroughly bad nurse with a first-class certificate. I do not say that this is anything but an exceptional case, and I fancy that nothing would have made the second individual into a good nurse, but

I do think that an examination by perfectly impartial people would have resulted in a different verdict, which would have been nearer the truth.

I would therefore advocate qualification of nurses by examination in every case, and registration of all nurses just as of doctors. High examination fees would not have to be charged, and indeed would not be necessary.

I hope that you will have other replies on this subject, particularly from nurses themselves, if any have time to write nowadays. The matter is certainly one of sufficient interest to deserve a thorough discussion.—I am, dear sir, faithfully yours,

Lamu, GEOFFREY DUNDERDALE.
British East Africa,
April 12th, 1916.

DEAR SIR,—In case Dr. Maxted's enquiries concerning the treatment of "concussion blindness" by hypnotism have not yet been answered, I am sending you a short reply, as I had the pleasure of being associated with Captain Ormond in treating his earlier cases. Every patient cannot be subjected to hypnotic suggestions, but the vast majority can. I believe that it is likely to be successful in every variety of war neurosis if the subject wishes to get well and is willing to undergo treatment after its nature has been explained to him. These cases are on the whole much more amenable to treatment by suggestion than the ordinary neurosis of peace time. I am quite sure too that any medical man can carry out the treatment "without previous knowledge and experience of such matters." Before I had ever hypnotised a patient myself I taught at least a dozen of my clerks in the Neurological Department how to do it, and without exception they succeeded. My personal experience dates from early last year and is almost confined to soldiers. Both in England and in military hospitals in the Eastern Mediterranean I have shown numerous officers how it is done, and they have found no difficulty in carrying it out. I have gradually come to use a method of extreme simplicity. The patient, with his eyes closed, lies in bed or sits in an easy chair, preferably in a darkened room, in the position which he would choose if he were settling to sleep. He is told not to listen to what is said to him, but to concentrate his mind on some pleasant mental picture, such as his home, just as if he wished to dream about it. In a monotonous low voice he is told that he is getting drowsy, his eyelids are getting heavy, he is falling asleep. Without waiting to test whether he is asleep or not—as it is immaterial whether he is deeply hypnotised or not hypnotised at all so long as he is not listening to what is said—curative suggestions are then repeated over and over again. He is told that he will see when he wakes, his eyes will be as strong as they ever were, that he will never be troubled with his eyes again, and so on, the suggestions being continued without interruption for five or ten minutes. The patient is then told to wake up in a quarter of an hour, or if it is late in the evening—a very suitable time for treatment—he is told to stay asleep until 7 or 8 a.m. He should not be examined or cross-questioned about his condition until he is fully awake.

I sometimes get a patient to fix his eyes on a bright object, such as a coin, for a minute or two before he closes his eyes, and sometimes press with my hand on his forehead when I make the suggestions, but neither of these methods is at all essential, and the former is of course impossible in cases of functional amblyopia.—Yours truly,

ARTHUR F. HERTZ.
Salonica, May 7th, 1916.

DEAR SIR,—Some weeks ago I read a very interesting article in the G.H. GAZETTE on "Common-sense Eugenics," by C. H. J. G., in which he mentions that Bertholet, of Lausanne, has found that alcohol has a "very rapid and profound action on the germ plasm."

May I, as an old Guy's man, ask you as a great favour to let me know the title of Bertholet's article, and where I can obtain a copy; or some account of his experiments. I am isolated from access to medical literature, hence my request, which, however, I trust will not give you too much trouble.—Thanking you, I am, yours truly, G. R. M. POLLARD.

Burn's Cottage,
Moffat, Scotland,
May 17th, 1916.

DEAR SIR,—I see that you are asking for the names of Guy's men who are on Active Service. I have the honour to hold the rank of Captain in the East African Medical Service for the period of the campaign here.

Will it be possible to obtain a complete list at some future date.—Yours faithfully,

Advanced Base Hospital, GUY HARCOURT PEALL.
Kajiado,
April 12th, 1916.

Appointments.

R.N.V.R.

St. G. B. B. Gray has been appointed Surgeon-Probationer.

R.N.M.S.

The following appointments have been made:—

To be Surgeons to the Staff-Surgeons—A. T. Rivers, K. H. Hole, G. F. Syms.

R.A.M.C.

The following appointments have been made:—

To be temporary Major—Herbert French.

Temporary Lieutenants to be Temporary Captains—R. Denman, E. R. Stone, J. B. Mason, H. Meyrick-Jones, F. D. S. Stone, L. G. Davies, T. Stansfield.

To be Lieutenant—H. Bercastle.

To be temporary Lieutenant—W. M. Thomas.

To be temporary Honorary Lieutenants—A. Buchanan, K. Black.

Temporary Lieutenant E. Fryer has relinquished his commission.

Capt. A. J. Cleveland to be temporary Major whilst employed at the Norfolk War Hospital.

To be temporary Lieutenants—J. L. Whatley, A. H. Smith, A. E. Rayner.

Temp. Lieut. R. W. L. Camp relinquishes his commission.

Territorial Force, R.A.M.C.

Welsh Field Ambulance.—Major J. Evans to be temporary Lieut.-Colonel whilst in command of a field ambulance.

Indian Medical Service.

Major A. Miller to be Lieutenant-Colonel.

Captain H. Watts to be Major.

Civil.

Graham Simpson, M.R.C.S., L.R.C.P., has been re-appointed Honorary Surgeon to the Sheffield Royal Hospital.

N. H. Carruthers, L.R.C.P. Lond., M.R.C.S. Eng., has been appointed Certifying Surgeon under the Factory and Workshops Acts for the Acle District of the County of Norfolk.

Honours.

Mentioned in Despatches.—Colonel C. J. Symonds, R.A.M.C., and Colonel A. H. Tubby are mentioned in Sir Ian Hamilton's despatch of December 11th, 1915, concerning the operations in Gallipoli.

At its quarterly meeting on May 2nd the Royal College of Physicians of Edinburgh resolved to offer its Diploma of Membership to Captain J. L. Lauder in appreciation of his conduct at Wittenberg.

To be C.B.—Colonel C. J. Symonds, R.A.M.C.

The Military Cross has been conferred upon Capt. J. Lennox Stewart, R.A.M.C. (attached to the 1st Gordon Highlanders).

The Order of St. Sava—a foreign decoration—has been conferred with the approval of His Majesty the King upon Capt. C. R. Nicholson, 5th class.

E. G. Schlesinger has been awarded the "Croix de Guerre."

Roll of Honour.

Died of Wounds.—Captain E. B. Hartnell, R.A.M.C.

Wounded.

Temp. Capt. H. A. Pallant, R.A.M.C.

Papers by Guy's Men.

R. A. Greeves, F.R.C.S., in collaboration with W. T. Holmes Spicer, F.R.C.S.: On superficial linear keratitis, together with an account of the pathological examination of two affected eyes.—*Proceedings of the Royal Society of Medicine*, March, 1916.

W. M. Mollison, M.C.: Case of tumour of concha after radical mastoid operation.—*Ibid.*

W. M. Mollison, M.C.: Audible tinnitus in a boy.—*Ibid.*

J. Lewin Payne, L.R.C.P., M.R.C.S., L.D.S.: Discussion on war injuries of the jaw and face.—*British Dental Journal*, May, 1916.

C. C. Holman, M.B., B.S. Camb., F.R.C.S. Eng.: Spinal anæsthesia, with special reference to the use of novocaine.—*The Lancet*, May 6th, 1916.

Kenneth W. Goadby, L.R.C.P., M.R.C.S., D.P.H. Cantab.: Ulcerative stomatitis (Report to the Medical Research Committee).—*Ibid.*

Laurence C. Panting, M.D., B.Ch. Oxon., M.R.C.P. Lond., F.R.C.S. Eng.: On the association of jaundice with appendicitis.—*The Clinical Journal*, May 10th, 1916.

M. S. Pembrey, M.D., B.Ch., in collaboration with F. E. Shipway, M.D.: Observations on the influence of anæsthetics on the temperature of the body.—*The Lancet*, May 13th, 1916.

R. P. Rowlands, M.S., F.R.C.S.: The use of the tourniquet. A plea for its more thorough use in peace and war.—*Ibid.*

J. H. Ryffel, M.B., B.C., B.Sc.: Pyelo-nephritis with glycosuria.—*The Quarterly Journal of Medicine*, January, 1916.

J. W. Beacock, L.D.S. Eng.: The common-sense of asepsis.—*British Dental Journal*, May 15th, 1916.

W. Courtney Lyne, L.D.S. Eng. (communicated by Montagu F. Hopson, L.D.S. Eng.): The significance of the radiographs of the Piltdown teeth.—*Ibid.*

R. P. Rowlands, M.S., F.R.C.S.: Jejunostomy and jejuno-colostomy.—*British Medical Journal*, May 20th, 1916.

Capt. H. P. Gibson, R.A.M.C. (in collaboration with Major C. J. Coppinger, R.A.M.C.): Inoculation of man with mixed vaccines containing bacillus typhosus, bacillus paratyphosus A., and bacillus paratyphosus B., with regard to the reaction produced, and the antibody formation.—*Journal of the R.A.M.C.*, May, 1916.

Major A. J. Hull, F.R.C.S., R.A.M.C.: White gangrene.—*B.M.J.*, May 27th, 1916.

R. O. Moon, M.D., Oxon., F.R.C.P. Lond.: Typhus fever in Serbia.—*The Lancet*, May 27th, 1916.

Major A. J. Hull, F.R.C.S., R.A.M.C.: The treatment of gunshot wounds by packing with salt sacs.—*Ibid.*

H. H. Moyle, M.R.C.S., L.R.C.P. Lond.: The odour of paint as a cause of plumbism.—*Ibid.*

Guy's Hospital Nurses' League.

[With acknowledgments to *The British Journal of Nursing.*]

THE Annual Dinner of the Guy's Hospital Past and Present Nurses' League is always a very pleasant function, and that on May 5th was no exception to the rule, although the work of the members in connection with the war and the lack of railway facilities was, no doubt, responsible for the absence of some familiar faces.

Miss Haughton, who presided, was supported by Miss S. A. Swift, R.R.C.; Miss Minnie Leng, home from Egypt; Miss E. Margaret Fox, Miss Atkey, and others, and a very excellent dinner was served in the Dining Hall of the Nurses' Home, the most attractive in London. We think the members of the League must wish that the purchasing power of a shilling were always as large as it is when they pay for their League Annual Dinner of four courses at Guy's Hospital.

Tea and coffee were served in the hall after dinner, and some excellent vocal and instrumental music was meanwhile provided by members of the nursing staff. Guy's Hospital seems to have a steady influx of musical talent amongst its probationers.

The chair at the business meeting, which was unusually brief, was taken by Miss Atkey, who congratulated Miss Swift on her dual honours as a recipient of the Royal Red Cross and as a Lady of Grace of the Order of St. John of Jerusalem.

THE YEAR'S WORK.

Miss Haughton, as Hon. Secretary, presented the report of the year's work, which stated that 175 week-ends and days off had been spent at the Cottage and 1,573 short visits for tea, etc.

Very little had been done on account of the war with regard to the different Societies and Clubs. The Musical and Debating Societies had held no meetings, nor had there been any Lawn Tennis or Swimming Tournaments, though both the Tennis Court and the Swimming Bath had been used a great deal.

In December a small gift and greeting card were sent to Guy's Nurses working abroad with best wishes from the Nurses' League.

In conclusion, the report recorded with regret that the League had lost three members by death since its last Annual Meeting: Miss E. Witherow, Miss Beatrice Cheesman, and Miss Helen Herrman, formerly Sister of the Accident, Mary, and Clinical Wards.

STATEMENT OF ACCOUNTS.

In the absence of the Hon. Treas., Mrs. Cameron, Miss Haughton also presented the Statement of Accounts. The receipts for the year were £301 5s. 1d., and the expenditure £227 7s. 7d. There was, therefore, an excess of income over expenditure of over £70, which with the balance which was in hand at the beginning of the year left a sum of £118 13s. 1d. in hand; but this would be greatly reduced by the printing of the Register of Guy's Hospital Nurses. As the Governors had promised to help with building the extension of the Cottage as soon as the war is over, the League had not asked for the grant of £300 they had given for several years. Now that the debt on the Cottage had been brought down to £1,000 the yearly subscriptions provided sufficient funds, if there were no extraordinary expenses. This year the subscription of the Sisters and Administrative Staff had been reduced from 10s. 6d. to 5s. and of the third year nurses from 12s. to 10s.

The League had voted £5 5s. to the Club started by Mrs. Robertson Eustace for Army Nurses in France as a slight recognition of the kindness members had received there.

The great number of Honours conferred on Guy's Nurses during the war were then enumerated. These have already been published in this journal.

Nearly 200 Guy's nurses were working in connection with the war in Egypt, Salonica, on the way to Mesopotamia via Bombay, in France, Flanders, and British East Africa, and Nurse Plant was interned in German East Africa.

MEMBERS OF COUNCIL.

Miss Smith then announced the result of the ballot for the election of members for the year 1916, as under:—

Nurses' Library.—Sister Light (Miss Payne) and Nurse Claxton.

Photographic Society.—Sister Mary (Miss Edmonds) and Nurse F. Edwardes.

Needlework.—Sister Naaman (Miss New) and Nurse S. Taylor.

Swimming Club.—Sister Violet and Nurse Hughes.

Nurses' Choral Society.—Sister Queen (Miss Hinds) and Nurse Wadlow.

Nurses' Tennis Club.—Sister Astley Cooper (Miss Maher) and Nurse Burton.

Nurses' Debating Society.—Sister Kirby and Nurse Macfarlane.

Mrs. Fagge, Mrs. Charters Symonds and Miss Webster were elected Hon. Members of the Council.

On the proposition of Miss Sheldon, votes of thanks were accorded to the outgoing officers. Mrs. Cameron, Mrs. Lauriston Shaw, and Miss Sheldon have been appointed by the House Committee their representatives for the ensuing year.

A most cordial vote of thanks was accorded to Miss Smith for all her work for the League.

THE COLLEGE OF NURSING.

Miss Haughton then gave a brief account of the foundation and objects of the College of Nursing, Ltd., and expressed the hope that it would not for long be known under that title, as one of its prin-

cipal objects was to get a Bill for the State Registration of Trained Nurses. They wanted to acknowledge all the work which had been done by the Society for the State Registration of Trained Nurses; and by Mrs. Bedford Fenwick for over 20 years.

One of their objects was to establish a Register, and they hoped by getting it ready, that they would be doing much of the work which would have to be done when the Bill was passed.

Miss Swift said Miss Haughton had not left much for her to say, but perhaps she realised more vividly than those in institution life how utterly things in the nursing world would be changed after the war.

After the Crimean War a forward movement was made in the organisation of modern nursing; now it was time to make another move forward.

When questions were invited, the inevitable one was at once put—

"Are you going to register V.A.D.'s on the College Register, or what are you going to do with them?"

Miss Swift replied it must be realised that the wounded could not have been successfully nursed without the V.A.D.'s to do some of the work; there were 12,000 in military hospitals alone. It would be for hospital trained nurses to regulate the examination of the V.A.D.'s.

Miss Haughton said the V.A.D.'s would not go on the Trained Nurses' Register.

In reply to a question as to the qualification to be required of trained nurses, Miss Haughton said that part was not settled. Nurses now in work must be recognised, there must be a time of grace. She expressed the hope that the College would have a fine building in a central position in London. They hoped for a large endowment from some generous donors, as a memorial of the war. By the time they had the building and the money they hoped to get an agreed Nurses' Registration Bill. There would be two subscriptions. Nurses would be put on the Register for half-a-crown, but to be Members of the College they would pay five instalments of 5s., or £1 in one sum.

After the business meeting some interesting lantern slides, from photographs taken by Sister Jentie Paterson before cameras were prohibited at the front, were shown.

Pass List.

Royal Colleges of Physicians of London and Surgeons of England.

At the Final Examination held April 4th to April 25th, the following candidates were successful in the subjects indicated :—

Medicine.—A. H. Ahmad, R. Aspinall-Stivala, H. J. Bensted, I. R. R. Brogden, J. S. Ellis, L. S. Gathergood, G. E. Kidman, I. Tewfik, E. C. de M. Morgan.

Surgery.—R. Aspinall-Stivala, H. J. Bensted, I. R. R. Brogden, P. D. H. Chapman, D. H. A. Galbraith, B. E. Jerwood, P. G. McEvedy, E. S. Phillips, R. H. C. Pryn, H. J. Vance, H. S. Wacher.

Midwifery.—J. F. C. Braine, P. D. H. Chapman, A. R. K. Dina, B. E. Jerwood, G. E. Kidman, T. E. Micklem, M. Pearson, F. N. Sidebotham, G. B. Tarring, I. Tewfik, R. R. Traill, M. B. M. Tweed, K. M. C. Woodruff.

At the Meeting of the Comitia of the Royal College of Physicians of London held on April 27th, and of the Council of the Royal College of Surgeons of England on May 11th, the Diploma of the L.R.C.P. and M.R.C.S. were conferred upon the following candidates who have passed the necessary examinations and complied with the bye-laws of the Colleges :—Harold John Bensted, Peter George McEvedy, Ingram Richard Rhodes Brogden, and Douglas Hugh Aird Galbraith.

At the First Professional Examination for Licence in Dental Surgery held recently the following candidates were approved in the subjects indicated :—

Mechanical Dentistry and Dental Metallurgy.—W. B. Burton, W. D. Hatton, A. Maher, S. C. Turner.

Dental Metallurgy.—A. B. Aldred, A, F Bartle, M. Ginsburg, A. N. Goudge, J. James, H. M. Marshall, S. E. Tweney, S. V. White.

Mechanical Dentistry.—T. B. Barton, P. J. S. de Wet.

University of London.

M.B., B.S.

At the Final Examination recently held the following candidates were successful: David Sydney Graves, Arthur Lisle Punch.

Supplementary Pass List.

GROUPS I. AND II.

The following candidates passed in one of the two groups of subjects :—

Group I.—Cyril Eaton Petley, Basil Sampson, Alfred George Simmins.

Group II.—Frederick Vivian Bevan-Brown.

Society of Apothecaries of London.

At the Examination held recently the following candidates passed in the undermentioned subjects :—

Medicine.—B. M. Tweed.

Forensic Medicine.—L. A. B. Moore.

Midwifery.—H. T. Lamb, B. M. Tweed, H. H. Vertue.

Medical Case-Taking.

Is that Philip Ward?

Yes.

If Mr. Hall is there will you tell him that he is wanted in Andrew Ward at once?

Eventually the message reaches the bewildered new Medical Ward Clerk; he cannot imagine why he should be wanted on this, the second day of his appointment. On arriving in the ward he learns that he is required to get from the mother, who awaits him, a history of

a small child who has been admitted into one of his beds. Immediately his thoughts fly to the detailed accounts of Case-taking in the official Hospital Blue Book on the subject, and in that storehouse of information for Medical Ward Clerks, "Clinical Methods." Nothing remains for the miserable clerk but to tackle the case as best he can. The following conversation ensues as he talks to the mother, whose appearance almost out-Borough's the Borough.

Clerk. Are you the mother of the baby in 17 bed?

Mother. Yes, doctor.

C. What's his name?

M. George 'Enery Swift, after his farver, doctor.

C. How old is he?

M. 'E'll be ten months come next Toosday two weeks, doctor.

C. Where does he live?

M. No. 10, Croft Buildings, Lion Court, just off the Ole Kent Road, doctor.

C. What has he come into the hospital for?

M. Well, you see, doctor, its like this; 'e's bin bad this last two weeks, then yesterday 'e took on terrible.

C. Yes, but what's his chief trouble, a cough, a pain, or what?

M. Well, doctor, 'e's got a nasty, wheezy, 'ackin' corf 'e 'as and 'is little navel starts dreadful, doctor; then 'e got the pain all over 'is little self, doctor.

The Clerk decides to put down "Admitted for cough and pain." He now has to turn to Family History.

C. Are you well, mother?

M. Oh, yes, doctor. I've bin first class ever since this little 'un came.

C. Have you ever been ill?

M. Nothink to speak of, yer know. I've 'ad the rumaticks badly and the fever, and I lay in this 'ere 'orspital once when my little gal, little Kathy, was born. They tell me I had dropsy o' somethink, and they brought me up to the 'orspital one night in a moter, they did, an' I was in Victoria Ward for a long time I was. I had such a nice young doctor when this littl'un was born, an' I saw 'im in a white coat I did when I brought the biby up last night.

C. Yes. Is the father well?

M. Oh, yes, 'e's in this 'ere war, 'e is; 'e bin out at Wipers and Saint Eloy and lots o' them places; but 'e bin 'ome in between, yer know.

C. Has he always been well?

M. Well, 'e lay in St. Stephen's ward once 'e did.

C. What was the matter?

M. I dunno; they called it pewmonia or somethink o' that.

The next thing for the now somewhat amused clerk to discover are the previous illnesses of the patient.

C. Has the baby ever been ill before?

M. No, never, doctor.

C. Hasn't he ever had whooping cough, measles, or any complaint like that?

M. Oh, yes, doctor; 'e 'ad the measles and one or two o' them things.

C. Has he ever had any running from the ears?

M. Oh, yes, 'e had the discharge alright, doctor, 'e did.

The last thing that has to be got from the mother is the history of the present illness; this is extracted in a decidedly piecemeal manner.

C. How did this trouble with the baby start, mother?

M. Well, 'e bin peevish like a'most this last three weeks then'e got the diarrhœa bad, and now 'e 'aint passed nothink for two days, doctor.

C. When did the cough start?

M. That started when 'e first took bad, doctor.

C. Has he been sick?

M. Last week 'e couldn't keep nothink down, doctor. I gave 'im orange juice and grivey, but 'twas all the same.

C. Has he been feverish long?

M. Well, about last Thursday it must 'ave bin 'e got very 'ot and cryin' when yer touched 'im like, wouldn't take no notice nor nothink, 'e just yelled as 'ard 'as 'e could. Then yesterday 'e got so 'ot as I couldn't ardly touch 'im, and 'e seemed to be in that pain that I couldn't bear to 'old 'im, so I thinks I better bring 'im up to the 'orspital.

The clerk feels decidedly grateful at the sudden burst of intelligence the mother displayed in making the last remarks in chronological order, and promptly dismisses her, having collected what he fondly hopes is sufficient for writing up a report.

The infant itself is yelling lustily while the nurse attends to its comfort, so, deciding that discretion is the better part of valour the clerk, feeling rather exalted at being called "doctor" so many times, postpones his examination until later, and goes out into the Park to talk about it.

H. O. L.

Reviews, etc.

After-Treatment of Operations. Fourth edition. By P. Lockhart Mummery, F.R.C.S. (Ballière, Tindall & Cox.) Price 5s.

This is the fourth edition of this useful book, and deals in clear and yet concise fashion with a subject whose importance to surgeon, nurse, and patient can scarcely be over-estimated, but to which, until recent years, comparatively little attention has been paid. While the main form of the book remains the same, considerable alterations and additions, rendered necessary in the light of recent knowledge, have been made in the text, and a new chapter on the later treatment of Gunshot Wounds, the fruits of the author's personal experience, has been added, and should prove of especial value at the present time.

The chapter on Surgical Shock has been entirely rewritten, and gives a lucid account of the results of the large amount of work recently carried out upon the causation, prophylaxis, and treatment of this important post-operative complication.

We can strongly recommend this book as being one which will give all those concerned in the after-treatment of the patient an excellent working knowledge of the difficulties and dangers which they may have to encounter, of the way in which these may best be avoided, and of the means to combat them should they arise.

Birth.

GLOVER.—On April 17th, at 27, Grosvenor Road, Aldershot, the wife of H. Harding Glover, of a son.

Marriage.

GREAVES—TENNANT.—On April 26th, at St. Luke's, Torquay, Edward Harrison Greaves, M.R.C.S., L.R.C.P. Eng., to Emma Hope Tennant, of Green Bank, Rawdon, Yorks.

F. A. K.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE past week has again seen a general circulation of a letter and Memorandum upon the well-worn subject of the Central Medical War Committee, on this occasion directly from the War Office. The Memorandum is clearly an official Government announcement, and does more to put the whole situation in a nut shell than any communication we have yet received. Certainly the nut is on the large side and the kernel none too easy for digestion, but still we consider that it brings home to us and medical men in general the exact state of affairs to-day as well as the inevitable developments of the future. Among the main points we notice that the Committee has now full power and authority, and that June 24th 1916, is a day sufficiently near to make personal decision as to enrolment a fairly urgent necessity. We believe that practically all qualified men have received a copy of the Memorandum, and would suggest that any who have not should study a borrowed copy with considerable care, and not for a moment imagine they are free from its influence because their own particular envelope has failed to reach them.

SOME months ago many daily papers supplied very free views upon the avoidable wastage of medical men in the British Expeditionary Force. Apparently these criticisms were supplied by R.A.M.C. officers themselves, but of late there has been complete silence on the subject.

During the past week, however, there has been a decided awakening to the old wrongs and four very definite suggestions are made. To us they seem of a decidedly revolutionary character, but as civilians we may be excused for imagining there might be some points in their favour.

On the assumption that on most parts of the front trench warfare appears likely to continue to the end of the campaign, it is suggested that in such divisions field ambulances should be done away with, so setting free about thirty doctors per ambulance, and that the medical unit should no longer be the division, but the army.

The other suggestions are that doctors should not be held in any position where only clerical work is required, and that it is more than wasteful towards the civilian population to keep a full complement of doctors doing nothing but still attached to field ambulances stationed at home.

It would be more than interesting to hear views on the subject from some of our own men who can speak from the practical experience which alone can give the true lighting to the facts.

To come back to the affairs at home; we hear from the College Committee that there is steady decrease in the number of meals served in the college dining room, and in justice we can at least say that this is not due to a corresponding decline in the quality of the food. We hear complaint as to the abnormal rise in prices, diminishing portions and the like, but it seems this is a natural sequel to the decrease of the total amount of food supplied as well as to the War. It is, we fear, an oft repeated request, but we offer no apology for again suggesting that, except when men have the usual but generally only occasional need to dine elsewhere they shall remember the difficulty which has always been found in the college catering department since the war so greatly reduced our numbers, and shall lend as much support to the home organisation as possible.

THERE is so much compulsion in the air now-a-days, and so varied the particular directions it takes, that at times we find ourselves demurring from force of habit, but there is one suggested form with which we most heartily agree. Owing to labour shortage, especially in the closely populated districts, local authorities intend to compel the burning of all household rubbish and odds and ends, instead of depositing them in the traditional dustbin for removal at a later date. It seems a trivial reform, but still should prove extraordinarily useful from a hygienic point of view.

RECENTLY we published the Report of the Curator of the Gazette Museum of Antiquities, and are now asked by him to appeal to the many holders of relics and objects of interest in connection with the Hospital's early days, such as coins, pottery, pewter, etc., excavated at various times in the grounds and neighbourhood. The Curator and all connected with the Hospital would more than appreciate the gift or loan of any such objects for exhibition in the Museum.

WE had hoped in this issue to reproduce a portrait of the late Sir James Goodhart, but, unfortunately, time and circumstance has prevented its publication earlier than in our next number.

WE offer our heartiest congratulations to Mr. J. J. Conybeare on his award of the Military Cross.

ON page 198 of the current GAZETTE we publish extracts from a most amusing publication, the *Evelyn News*, originating among the patients of the ward of that name. We may explain that this ward is devoted to the surgical treatment of recruits, and although one hears and reads many excellent little papers published by the patients of Military Hospitals, we think that for quality, if not for dimensions, these few sheets will hold their own with the best.

AT present there have left or are shortly leaving us several Guy's men and sisters for India and Salonika. We wish them all good luck in their travels, and would express our appreciation of the work they have done among us before the war has made its inevitable call.

Change of Address.

Surgeon Probationer St. George B. Delisle Gray, R.N.V.R., H.M.S. *Staunch*, c/o G.P.O.

Surgeon Probationer G. L. Cutts, R.N.V.R., H.M.S. *Narwhal*, c/o G.P.O.

Temp. Surgeon Rolf Creasy, H.M.S. *Royal Oak*, Grand Fleet, c/o G.P.O.

Lieut. A. Traill, Officers' Mess, No. 5 Camp, R.A.M.C. Training Centre, Salisbury.

A. S. Erulkar, M.D., B.S. Lond., M.R.C.S., L.R.C.P., Ahmedabad, India.

Capt. C. S. L. Roberts, R.A.M.C., 141, Secunderabad, Cavalry Field Ambulance, 2nd Indian Cavalry Division, Indian Expeditionary Force "A," France.

Douglas H. A. Galbraith, Lieut. R.A.M.C., c/o Messrs. Grindlay & Co., Bombay, India.

Capt. R. Stout, M.D., B.S., New Zealand Medical Corps, No. 1 New Zealand Field Ambulance, N.Z. Division, N.Z.E.F.

Capt. T. D. M. Stout, F.R.C.S., New Zealand Medical Corps, No. 1 New Zealand Stationary Hospital, N.Z.E.F., Ismailia, Egypt.

C. Warner, H.M.S. *Gloucestershire*, c/o G.P.O., London.

Dr. Bellingham Smith, 10, Devonshire Place, W.

(The Editor will be very glad to receive a post card with notes of any change of address.)

Obituary.

Sir JAMES FREDERIC GOODHART, Bart., M.D., F.R.C.P., LL.D.

JAMES GOODHART entered Guy's as a Medical Student in 1864, and worked here almost continuously until in 1898, at the age of 53, he resigned his position as Physician to the Hospital. A short break in his work at Guy's occurred when after being House Physician in 1869, he proceeded to Aberdeen in order to obtain a University degree. Returning to London in 1872, he was appointed Surgical Registrar, and two years later Medical Registrar. This somewhat unusual combination of teaching posts on both the Surgical and Medical sides of the Hospital Goodhart sometimes spoke of in later life as having been of special advantage to him in his own studies, and one can well believe that the broadness of view with which Goodhart approached borderland cases, may have been in part due to his early training in surgery. Another somewhat unusual feature of Goodhart's early staff appointments was his selection to the post of Demonstrator of Morbid Anatomy two or three years before he became Assistant Physician. This did not interrupt his clinical work, for almost at the same time he was appointed Physician to Out-Patients at the Evelina Hospital for Children. Nevertheless, as far as Guy's was concerned, the absence of duties in the wards enabled him to devote a large amount of time to the post-mortem room and museum. The work Goodhart did in these two posts which he held together, had no doubt a profound influence on his life's work. The early interest aroused in morbid anatomy is shown in the numerous contributions from his pen to the "Transactions of Pathological Society," from 1872 to 1886. His attachment to the Staff of the Evelina Hospital which lasted till 1888, was responsible for the wide experience in children's diseases which led him to publish his well-known text-book on The Diseases of Children. Generations of students at Guy's have profited by Goodhart's clear demonstration of the appearances found at post-mortem examinations and his powers of generalisation which enabled him to expound the relations between morbid processes in different organs and to explain the causes of the symptoms observed during life. As the successor in the Pathological Department of Wilks, Moxon, and Fagge, Goodhart maintained the tradition, still fortunately observed, that the Staff Demonstrator should with his own hand write out a full report of each autopsy. His reports are models of clear description and accurate observation, though they leave much to be desired in the way of legibility of handwriting.

At a time when there was no special department for children at Guy's, Goodhart's great interest in their diseases enabled students attending his general out-patient clinic to obtain a very thorough training in this special branch of medicine. In these early days complete physical examination was not the rule, and patients frequently resented the necessary undressing required for the purpose. To watch Goodhart first gaining the confidence of the outpatient mother, and obtaining her consent to strip her child, and then overcoming the scruples of the crying infant against the use of the stethoscope was an education in itself. The magnetic influence which caused him at one time to be the most popular consultant in London was never more effective than when he was dealing with a frightened or sulky sick child. He was thereby enabled to carry out in infants the principles he preached and practised when dealing with adults, of complete physical examination of all accessible organs, and thus to place the diagnosis and treatment of these cases on a scientific basis.

It was not only children who were attracted by Goodhart's sympathetic disposition and manner. His pupils and patients of all ages became greatly devoted to him, and it is not surprising that when the untimely deaths of his immediate seniors, Moxon and Fagge, opened the way for him to a prominent position in consulting practice, the demands for his professional services became very numerous.

Goodhart became Assistant Physician in 1877, full Physician in 1886, and Consulting Physician in 1899. For a few years he gave the nine o'clock lectures on Pathology during the Summer Session. These lectures were elaborately prepared and read, a fact which considerably lessened the interest taken in them by the majority of students. As a lecturer he was far more interesting when delivering, without obvious verbal preparation, a clinical demonstration on some obscure case, or elucidating some difficult problem by reference to his immense storehouse of clinical facts accumulated in hospital or private practice. He shewed himself on these occasions, and in debate at medical societies, to be an excellent extempore speaker, with a distinct gift of gentle humour. But in formal addresses or orations he preferred to write out his remarks in full, and although he

read such lectures with much expression, those familiar with his more colloquial discourses, wished sometimes that he would trust less to his notes. But these addresses always read well when they were printed, and some of them when published as separate volumes obtained a wide circulation. This was specially the case with an address on Common Neuroses, which greatly enhanced his reputation as a physician, not perhaps on account of any very original clinical observations it contained, but because it bore testimony to the author's sound common sense and sympathetic insight into human nature.

Goodhart's ward teaching was extremely popular with senior students and men already in practice. But in days when big crowds of students were commoner than they are now, Goodhart's band of followers was always select rather than numerous. Men found that what they learnt going round the wards with him was of more use to them in the great world than in the examination room. He had a high reputation for accuracy of diagnosis, and his forecast of the morbid changes that would be found in the P.M. room in fatal cases was remarkably true.

As time went on the visits to the wards, to which his "firm" looked forward with so much interest, were more frequently interrupted by urgent calls elsewhere than Goodhart regarded as compatible with his proper duty as Physician to the Hospital. His juniors were always ready to do his work for him and extremely anxious that his valuable clinical experience should not be lost to the Medical School. But as the calls of private practice became more insistent Goodhart finally severed his active connection with Guy's at the early age of 53. Some of his colleagues regarded this as somewhat in the nature of desertion from the post of duty, but all sympathised with his high sense of responsibility, which did not allow him to retain his office whilst unable to fulfil faithfully its obligations.

Goodhart was as popular with his colleagues in the Medical School as with the numerous professional confrères who habitually sought his aid in consultation. He had a wonderful capacity for getting through work and allowed himself few social relaxations. His busy professional life afforded him few opportunities for engaging in public work either in connection with his profession or in a wider sphere. But he was always accessible to any brother or sister in distress or difficulty, and his private benefactions were probably more conspicuous for their generosity than their judgment. He had no conspicuous hobbies, but was fond of travel. For many years he spent a winter holiday on the Riviera. He was extremely devoted to his home and family life. He married in 1879 Emma, daughter of Mr. William Bennett, of Ashgrove, who died in February, 1915. He leaves two sons, the younger of whom, Captain Gordon Goodhart, is well known to all at Guy's.

Goodhart generally enjoyed good health without which it would have been impossible for him to have carried on so large a practice. The death of his wife was a severe blow to him, and about the first anniversary of her death he began to show signs of the insidious malady which caused his death on Sunday, May 28th, in his seventy-first year.

It is now sixteen years since Goodhart gave up his active work at Guy's. To several generations of students he was, therefore, unknown as a teacher. But amongst the large number of professional friends who mourn his loss, none will do so more deeply than his colleagues and the past students of Guy's Hospital, who learnt to love and respect him while working with him within these walls.

The funeral of the late Sir James Goodhart took place on Ascension Day. His body was cremated, and late in the afternoon, after the memorial service, his ashes were laid to rest at Holtye, at the feet of the late Lady Goodhart.

At the memorial service at All Souls' Church, Langham Place, which was conducted by the Rector, Prebendary F. S. Webster, assisted by the Bishops of Islington and Woolwich and the Rev. Canon Goudge, D.D., there was a very large congregation, amongst whom were the following:—Mr. and Mrs. Goodhart and their little son, Capt. and Mrs. Gordon Goodhart, Colonel Sir Arthur Davidson, Equerry to H.M. Queen Alexandra and H.R.H. Princess Victoria, Dr. Frederick Taylor representing the Royal College of Physicians, Sir Rickman Godlee, Bart., representing the Royal College of Surgeons, Sir Richard Douglas Powell representing the Council of King Edward VII. Sanatorium, and Dr. Mitchell Bruce (the Consulting Staff of the Sanatorium). Dr. Hale White was representing Guy's Hospital, and amongst the many others present were Sir Henry Morris, Sir James Reid, Sir John and Lady Colley, Dr. G. F. Still, Lady Butlin, Mrs. W. J. Walsham, Mr. and Miss Lankester, Dr. and Mrs. Lauriston Shaw, Sir George Savage, Sir David Ferrier, Dr. De

Havilland Hall, Dr. Newton Pitt, Sir Lauder Brunton, Sir Dyce Duckworth, Sir Henry Burdett, Dr. Lewis Marshall, Dr. Atlee, Captain and Mrs. Ormond, Mr. Boydell Houghton, Mr. Reynolds Ray, Mr. Charles Higgens, Captain H. E. Counsell, Mr. and Mrs. Irwin Palmer, Mrs. Charters Symonds, Mrs. D. Lees and Mr. Kenneth Lees, Dr. and Mrs. Selwyn Harvey, Mr. Sutton Sams, Dr. John Fawcett, Sir Shirley Murphy, Sir Felix Semon, Dr. E. W. Goodall, Dr. H. V. Hickman, and many others.

Although there was a request that no flowers should be sent owing to the war, many beautiful tributes were sent to Holtye, amongst these being a large cross of white lilies and mauve carnations from H.R.H. Princess Victoria, "In grateful remembrance."

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

DEAR SIR,—Is it possible to write as one would wish about our late friend, Sir James Goodhart, Bart? It certainly is not possible to do justice.

It happened I was second H.-P. at Guy's in 1879 when he married and went on his honeymoon. I knew him well before that; he was with the late Dr. Hilton Fagge doing P.-M.'s, and in consequence of the latter examining at the London University and the then Dr. Goodhart's marriage, we two H.-P.'s had the P.-M.'s to do for the fortnight, and ever since Sir James has been a friend, which privilege I have always honoured.

There is no eulogy required as to what he has done for the profession, it has been so great, his careful training of men, who cared to be trained. When Medical Registrar his association with Moxon made him teach in such a way that to the thinking man was impressive, sound, and reliable; his books, lectures and writings are full of the best. He was careful, conscientious to a fault, and never gloomy, when hope had gone.

To me the many sides he had, always appealed—medicine, poetry, the idealist, and to some the gardener. It amused me to discover the latter when he last came to my house. Let's go into the garden. Oh, you have salt on your asparagus; my gardener objects! I shall insist. What are these strawberries? (it was late August). Those, the best Alpines crossed, would you like some? Next year he told me they were delightful, and to have them into October; later we improved on those.

It was always interesting to note the little sceptical, quizzical, yet humorous smile that met a not quite proved remark.

To every Guy's man he was always Goody. When I congratulated him on his Baronetage I told him he would be Goody to the end, and he said he hoped so. The loss will be difficult to fill, personally and generally, for he was one of the best of men. Hannah More's two lines fit the picture—

"To those who know thee not, no words can paint;
And those who knew thee, know all words are faint."

—Yours, F. B. JUDGE BALDWIN.

Draycott House,
Bodicote, Oxon.

ODE TO THE CHAIN GANG.

(SPECIALLY CONTRIBUTED).

From the *Evelyn News*.

When occupied in shifting screens
And other useful duties,
Remember that, though full of beans,
You're not exactly beauties.

Attired in roomy hose and kilt
(Which fits where'er it touches),
Your absence would be sorely felt
When business comes in rushes.

At 5 a.m. you're on parade
All smartly at attention;
Seeing that all the beds are made
And things we need not mention.

When terror stalks through Evelyn Ward,
And anxious "coves" are crying;
The chain gang works both long and hard
To keep the old flag flying.

"Black Jack" is taking his revenge,
And pains that sorely vex us,
Causing the patients all to cringe
And rub their solar plexus.

But with your noble aid, my boys,
Our troubles vanish like our dreams.
And when you march, oh dear, what joys,
To see your banners are our screens.

The head nurse, generous loving soul,
Appreciates your heavy toil.
And nightly hands you each a bowl
Of bubbly, sparkling castor oil.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Letters from France.

II.

THE prevailing note of war, at the base at all events, can be briefly summed up as an unhallowed monotony. Up the lines the fighting may be desperate, the issues of nations may hang in the balance, but at the base these activities scarcely ruffle our preternatural calm. A few more convoys of wounded, the influx of a few more "red hats," devilishly imposing in their 60 h.p. Rolls-Royces, a few of one's friends full of the enormity of cancelled leave, and the tide of war passes by, leaving one aghast at its futility. "What did you do in the great war, daddy?" the precocious infants of the recruiting posters might be imagined to ask, and "I was officer in charge of bread and meat" would be his sire's proud reply. Out here the humblest of us learn to be versatile, and mastering army routine takes an intellect of no mean order. There is a story of a battalion which, finding itself almost annihilated by trench rats, sent in an indent for traps. After the usual delay the indent was returned with a note stating that the traps in question could not be sent unless these were described in the proper manner. The ordnance list was turned up, and it was found that the proper description should have been: traps, rat, troops, for the use of; which, after all, would hardly have occurred to anyone not in the spirit of the game. Similarly the classification of the various categories of hospitals seems to be on somewhat Gilbertian lines. A stationary hospital differs from a general hospital in being the more mobile unit; a mobile hospital, on the other hand, never moves at all. Still, as an officer remarked the other day, these names are retained for convenience.

Perhaps the thing which is most striking, amid all the changed conditions of war, is the entire absence of young Frenchmen, or, indeed, of men of any age but threescore years and ten. In England the picture press prates pleasantly of the supplanting of men by women in industry, but here is an accomplished fact. Daily I entrust my chin to a fair *coiffeuse*, and my life to a *battman* of the gentler sex. Even the few *poilus* that one does see about on leave all seem well into middle age, though whether the universal beard accounts for this impression I cannot say. Very businesslike and warstained they look in their new sky-blue uniforms and grey helmets, though they seem to lack the glow of absolute health which is our own Tommies special prerogative. Meanwhile Young France is keeping its gallantry in trim by a method which can be best described as "*le flirt par correspondence.*" Every week the columns of that vivacious journal "La Vie Parisienne" are filled with little notices demanding a "marraine" (a female friend, the early Victorians would have styled it) to aid some brave young hero in killing his "*cafard.*"

As I hinted in my last letter, some may seem a little daring in comparison with our own timid efforts in that direction, but at the risk of scandalising the readers of the G. H. GAZETTE I append a few random selections. Such is the demand upon the editor's space that prospective advertisers are informed that a delay of at least three weeks is to be expected before insertion. "Two blue devils," commences a typical example, "weary of being in communication with the Bosch by barbed wire, desire epistolatory communication with two *jolies marraines.*"

"To dry the tears caused by lachrymatory shells, three young officers seek gay and affectionate *marraines.*"

Or in a burst of poetry—

"*Une blonde aux yeux roux,*
Serait pour mes pensées
Un oreiller bien doux."

There is a burst of manly stoicism in the appeal of three young lieutenants "not depressed either morally or physically, and in spite of twenty-one months at the front, *sans cafard,* for correspondence with *marraines,* who must be young, beautiful, and *bien faites.*"

"Help!" cries another, "three officers are drowning in the mud, *marraines* required."

So you see the gallantry of France is unquenched and, one presumes, unquenchable. But if this volatile element is difficult to suppress, other and traditional qualities are undergoing a transformation, inevitable given the conditions of a war by siege. It is mere vanity to be reputed the finest soldier in Europe if the measure of your valour is to stand in a ditch half full of dirty water and dodge shrapnel and high explosive. And if there is one thing likely to undermine your *morale*—excellent, of course, as the official *communiqué* assures you—it is this Fabian policy of masterly inactivity. And if, added to your other woes you have bad clothes, leaky boots, and insufficient nourishment, your gaiety and that of your comrade poilus will become a standing miracle. But is the *poilu* really gay? True we have the accumulated evidence of the picture press of England and France to vouch for the fact, but if, being perhaps one of those sceptical fellows who refuse to regard L'excelsior and L'Illustration as being one of the eternal verities, one takes the trouble to examine the *poilu—tel qu'il est,* this vaunted gaiety is apt to dissipate into something not far removed from a rueful grin.

I have no wish to bring upon the G. H. GAZETTE the doubtful honour of quotation by the *Berliner Tageblatt* or the *Kolnische Zeitung,* or even the lesser evil of a leading article in the "Detroit News-letter," but this hypothetic gaiety is a canard which no sensible person would wish to perpetuate. Not that there is any need to swing to the opposite extreme and assume that the *poilu* is in the last stages of demoralisation. No, he is just a very human fellow,

heartily sick of the trenches, very anxious for the war to end, and equally certain that the Bosch must be finally crushed. For the rest, if you believe that high feeding is responsible for his gaiety, note the daily menu: 7 a.m. "*le jus*," *i.e.*, coffee without sugar or milk, 250 c.c.; 10 a.m. "*la soupe*"—soup made with meat and vegetables, followed by the same meat that has gone to the making of the soup, 150 grs., or if you happen to be under 20 years of age 200 grs.; bread is also supplied. At 5 p.m. the same menu is repeated. On certain days a quarter of a litre of wine is supplied. Tobacco is not supplied free, but a special packet is sold once a week for three sous containing, I think, about 100 grs. Any further supplies required must be purchased from the local *débit* at current rates; for this end, perhaps, a beneficent government has raised the soldiers' pay from one to five sous a day. But, you will exclaim, doubtless special facilities are afforded to parents who wish to send parcels of comforts, etc., to their sons in the firing line? Oh, yes, for the modest sum of one franc ten centimes a parcel of one kilogramme may be sent to the front, and by a supreme grace families proving their poverty are allowed one packet a month free of postal dues. Soldiers' canteens are very rare, and as for rest and recreation huts, such as are provided for our troops in such profusion, they are non-existent. "Ca c'est du *luske* (luxe)" the *poilu* would exclaim in his expressive argot, if he heard of the princely treatment accorded (and only too justly) to our men in the field. As compensation, perhaps, for these and similar privations the government distributes medals with a lavish hand. Before the war it was rare to see a Frenchman over forty who had not in the lapel of his coat a ribbon of some sort, were it only the green and yellow of the *mérite agricole*, or the purple of the *palmes academiques;* at present few are the hardy warriors back from the lines who do not wear the bronze star of the *croix de guerre*, many, in addition, boast the legion of honour and the *medaille militaire*, so, since here one wears medals and an inch or more of ribbon, the effect is, to say the least, imposing.

Much popular sentiment is being lavished on those young hopes of France, the classes '15 and '16. The former, owing perhaps to their adoption of the universal sky blue uniform, are dubbed in popular and affectionate parlance "*les bleuets*," the latter, for no reason that I have yet discovered, "*les Marie-Louis.*" Such was the need of men in the early months of war that after a training barely exceeding the statutory minimum of forty days, many of the *bleuets* were despatched to the front. As in peace time the process of converting a civilian into an efficient soldier is supposed to take three years, this war-time celerity is the more to be marvelled at. Needless to say, the news of their departure was a matter for the wildest enthusiasm; amid a thousand similar outbursts I cull three lines from Lesclide's fine poem "*Les Bleuets*"—

Le cœur des nôtres parle, ils sont tous fils de France!
Ils s'en vont en chantant dans leur jeune vaillance;
En fiers bleuets se sont mués nos frais muguets!

Yes, they are gone, and of many there remains but the memory of their youth—a far-off sweetness.

G. H. F. G.

Honours for Guy's Nurses.

WE are pleased to announce that the following Guy's Nurses have been awarded the Royal Red Cross of the First and Second Class:—

FIRST CLASS DECORATION.

Miss H. Suart, Q.A.I.M.N.S., Acting Matron, Cambridge Hospital, Aldershot. Guy's, October, 1896, to February, 1904.

Miss Amy Willes, Q.A.I.M.N.S., Acting Matron, Connaught Hospital, Aldershot. Guy's, October, 1896, to October, 1899. Sister, ditto, June, 1903, to April, 1904.

Miss Enid M. Newton, T.F.N.S., Matron, No. 21, General Hospital, Alexandria, Egypt. Guy's, May, 1897, to July, 1900. Sister, ditto, September, 1902, to February, 1904.

Miss C. Todd, Matron, St. John Ambulance Brigade Hospital, Etaples, France. Guy's, November, 1903, to March, 1907.

SECOND CLASS DECORATION.

Miss L. E. Jolley, Q.A.I.M.N.S.R., Acting Sister, British Expeditionary Force, France. Guy's, February, 1903, to June, 1906. Sister, ditto, September, 1906, to May, 1908, and 1909 to 1910.

Miss A. M. Blott, Sister, Queen Mary's Royal Naval Hospital, Southend-on-Sea. Guy's, November, 1902, to April, 1906. Guy's Institution to November, 1914.

Miss B. A. Hope, Matron, Thorncombe Military Hospital, Bramley, Surrey. Guy's, April, 1897, to April, 1898.

Miss M. J. Nawn, Sister, Crescent War Hospital, Croydon. Guy's, December, 1900, to January, 1904. Guy's Institution to August, 1905.

Miss S. A. Selby, Sister, Endsleigh Palace Hospital, S.W. Guy's, April, 1910, to April, 1913.

Miss L. G. Sheild, Sister, Officers' Section, Guy's Hospital. Guy's, February, 1904, to February, 1907, Sister since September, 1909.

Miss E. Stedman, Staff Nurse, King George Hospital, Stamford Street, S.E. Guy's, May, 1887, to May, 1890. Guy's Institution to 1892.

Miss D. M. H. Woollett, Staff Nurse, King George Hospital, Stamford Street, S.E. Guy's, December, 1911, to April, 1915.

Carcinoma of the Colon: Its Early Recognition and Removal.

CLINICAL LECTURE BY R. P. ROWLANDS.

GENTLEMEN,—As most of the subjects of cancer of the colon die from the local effects of the disease and not from dissemination or recurrence, it is clearly very important to recognise and operate for this condition while the growth is still removable and especially before the intestines become over-distended and severely damaged by increasing obstruction. When an operation is undertaken before complete or severe obstruction develops, the disease can be cured by a single operation, much time and suffering saved, and the misery of colostomy and repeated operations can be avoided. Timely resection is not very dangerous, and offers a good chance of freedom from recurrence, better here than anywhere else in the gastro-intestinal tract. To-day I shall limit my remarks to those fortunate cases which can be safely treated by primary resection, leaving to another lecture a discussion of those distressing and neglected cases which are too late for this ideal treatment. Many hospital patients do not seek advice until complete intestinal obstruction develops.

Symptoms and signs.—When a patient about or past middle age complains of constipation, especially if this alternates with occasional attacks of spurious diarrhœa with offensive stools, flatulent dyspepsia, griping pains, weakness, wasting and anæmia, a growth of the colon should be suspected, and the whole course of the colon should be very carefully examined. Rectal, vaginal and bimanual examination of the pelvis, and of both loins may enable the surgeon to feel a tumour or a mass of scybala above the obstruction. But it is difficult to feel a growth near the hepatic flexure, and practically impossible to feel a small annular stricture at the splenic flexure. The passing of blood and slime is very suggestive, and generally indicates that the growth is below *the tranverse colon.* Visible peristalsis is a very valuable sign, and repeated gurgling at one spot sometimes terminates griping attacks, and indicates the probable site of the obstruction.

Diagnosis.—X-ray examinations after a bismuth meal, or similar enema, may reveal and localise the obstruction. Sigmoidoscopy is often very valuable in completing the diagnosis and localising the disease, when the latter is within twelve or fourteen inches of the anus. When the obstruction is higher the sigmoidoscope may reveal inflammation of the mucosa with blood and slime, strongly suggestive of the disease, and in any case it shows that colostomy can be avoided, even if the growth is not removable, for a short circuit can be performed engaging the healthy pelvic colon.

Cancer of the colon is commonly mistaken for colitis or dysentery, and this is all the more easy because more or less severe colitis is usual above and below the growth. A man came to me recently who had thought he had caught dysentery from some soldiers returning from the Dardanelles, but a growth in the pelvic colon was the cause of the symptoms. Every case of colitis should be examined very carefully for growth of the colon, and this is all the more imperative if parasitic dysentery can be definitely excluded, and when there is no fever, and when the blood and slime are not mixed with the fæces.

Bleeding internal piles and internal fistulæ with associated proctitis and diarrhœa may be mistaken for growth of the colon, and the abdomen opened needlessly unless care is taken to consider and examine for them.

When cancer of the colon is strongly suspected, an early exploration is urged, for with early removal of the growth the prognosis is good both as regards immediate recovery and permanent immunity. Even if the diagnosis is not confirmed some other condition curable by operation is usually discovered, such as appendicitis with inflammation about the cæcum, ascending or pelvic colon. A retro-colic adherent appendix is a common discovery, the posterior wall of the colon being thick and œdematous. Apart from definite colitis the removal of an appendix intermittently discharging pus into the colon often cures a chronic diarrhœa.

Pericolitis due to pelvic adhesions or diverticula of the colon is another common source of error, of which I published several instances.*

Indications for and against resection.—

(*a*) Local. The smaller the size, more definite the outline and the more movable the growth, the more likely is it to be removable. Therefore mobility is of importance in pointing to the absence of adhesion. The absence of tenderness and the signs of inflammation are also important. When suppuration has occurred

* *Lancet*, 1910, vol. i., p. 1194.

around the growth the dangers and difficulties of resection are greatly increased. The adhesion of the growth to the parieties is not so important as it used to be considered, for the colon and parietal peritoneum can be mobilised. Adhesion and especially invasion of small intestine, stomach, pancreas or kidney are more serious, but may be met occasionally by careful separation or resection of a part of the invaded viscus. Signs of growth in the liver, especially nodular enlargement, ascites or nodules of growth felt on pelvic examination indicate invasion of the peritoneum and make exploration unnecessary. In many cases it is only possible to decide if a growth is removable after opening the abdomen.

(*b*) General. Is the patient strong and well enough to bear a severe operation? Above all, is the obstruction complete or nearly so? If the obstruction is complete, primary resection is very rarely successful Dr. Elliot* states that the mortality of primary resection and immediate suture in these cases is at least 50 per cent. even in the hands of the best surgeons, and in some hospitals it is as high as 85 per cent. Peritonitis is the chief cause of death, and this is nearly always due to the fact that the most perfectly placed sutures do not hold. Another cause of death is shock partly due to an unnecessarily long operation. *Where complete obstruction is present one of the following steps should be adopted:—*

1. *Colostomy* above the obstruction and well away from it.

2. *Short-circuiting*, such as ileo-colostomy.

3. *Resection with drainage after Paul's method.*

These will be discussed in a subsequent lecture.

If the obstruction is incomplete the bowel must be emptied and the patient carefully dieted for a week before the operation of resection is attempted.

The following three cases serve to illustrate my lecture. They give detailed accounts of the examinations and operations which may prove valuable to you:—

CASE 1.

Dr. M., aged 48.—His father and one brother died of cancer of the bowel. He himself had suffered for years from piles from which bleeding had often occurred. For the last two years there has been a good deal more bleeding from the bowel, and this has been often associated with pain in the left iliac region. In March, 1910, the bleeding became more severe and came on quite apart from defæcation. He gradually got into poor health and wasted a good deal, and a fortnight ago he fainted. Mucus and much blood escaped from the rectum. The patient saw several consultants and was referred to me for operation on 19th October, 1910.

I felt an elevated growth high in the rectum. I could not find any stricture, but only what appeared to be an ulcer occupying one side of the bowel. *During the examination the growth receded out of reach*, clearly showing that it was fairly high in the bowel, but had intussuscepted into reach. Then the receded growth could be felt through the anterior wall of the rectum. It was thought that an abdomino-anal resection would be the best operation.

The bowels were well cleared out, and the patient was kept at rest for three days and carefully prepared on a diet leaving little residue. Morphine *grain 1/3, and atropine grain 1/150, were injected an* hour before the operation on October 22nd, 1910, and axillary saline infusion was also commenced and continued during the operation, five pints in all being given. Open ether was administered by Mr. Plumtre. The abdomen was opened through the lower and inner part of the left rectus, and the growth was at once found in the lower part of the sigmoid loop about nine inches from the anus. It was freely movable, *and some enlarged glands were felt in the meso-sigmoid.* The liver and lumbar glands were normal. The high Trendelenburg position was adopted, and it was decided to resect the growth abdominally and join up the colon end to end. This was carried out, nine inches of bowel and the lymphatic area being removed, *i.e.*, all the draining lymphatic glands, from the growth to the origin of the left colic artery, were removed in one piece with the growth. Microscopic *examination of the enlarged glands showed inflammatory* changes only. End-to-end union was performed with two silk sutures. The first was a continuous Connell, and the second a continuous Lembert suture. The packs were removed and the rent in the mesentery was closed as far as possible with catgut sutures, and the bowel was replaced. The peritoneum was cleansed of blood, and the wound was completely closed in layers. The operation lasted an hour and a quarter, and at the end of it the patient was not collapsed. On opening the piece of bowel removed it contained no fæcal matter, only a little blood-stained mucus. An ulcer two inches long and one and a half inches wide with rampart-like edges was seen. The mucous membrane around the ulcer was much congested and inflamed. The ulcer did not encircle the bowel or appreciably narrow the lumen; it had clearly obstructed and caused pain only by intussusception. There were very few enlarged glands in the mesentery, except quite close to the growth, which was a columnar-celled carcinoma.

* *Ann. of Surg.*, 1905, vol. xlii,, p. 688.

The patient did very well, the wound healed without any trouble, and he left the home within a month. He was at work at his busy practice within two months of the operation. He was quite well four years later.

CASE 2.

Another patient, a man aged 68, with a massive, adherent growth of the first part of the pelvic colon, bore wide resection well, and in spite of a complicating enlargement of the prostate, was able to leave London for his home three weeks after the operation, which was performed in November, 1912. He was well in August, 1913, but died, probably of recurrence, about six months later.

CASE 3.

Mr. M-E., aged 62, had had occasional attacks of diarrhœa for nine months.

History.—February 27th, he sent for his doctor because he had severe bleeding from the rectum; also a great deal of mucus. Rectal examination for piles or growth was negative. He was kept quiet and astringent medicines given. There was some tenderness and resistance over the sigmoid, and the abdomen was rather distended and flatulent. There was no vomiting and no wasting. In April he had another similar attack, and his case was considered suspicious. He was sent to me for examination, and I wrote—

"I have examined Mr. M-E. very carefully in various ways, and I have come to the conclusion that he probably has a growth of the bowel, probably above the middle of the pelvic colon. I could introduce the sigmoidoscope to the full extent of about 12 to 14 inches without seeing any growth, but the appearances of the mucous membrane in this neighbourhood were very suspicious of the presence of a growth, for there was some inflammation and a great quantity of blood-stained mucus to be seen. Moreover, there is some pain in the left iliac region, and some tenderness on deep palpation in that neighbourhood. I could find no enlargement of the liver. I think the presumption of the presence of a growth is so strong, although there is no absolute proof, that the abdomen ought to be opened without delay, and the patient has consented to this. I suggested that he should keep in bed on a low diet and have the bowels well opened, and have the operation performed at 9.30 a.m. on Tuesday next, the 27th inst. Should you be able to come up I should be glad. I have secured a very good anæsthetist, and also I shall bring my House Surgeon to help me at the operation, which may be difficult. I have explained to Miss E. that it is a severe and difficult operation, not without considerable risk, but that it is far better to take this risk than to wait natural developments. I hope to be able to resect the growth and join up the bowel end to end. Failing that, a short circuit will be practicable so that colostomy will, I think, be not necessary."

Operation on April 27th, 1915.—The patient had been very well prepared, so that his bowels were empty. Dr. S. gave ether after morphia and atropine. A very long vertical incision was made through the inner fibres of the left rectus. I felt the growth at once in the upper limb of the pelvic colon loop. It was easily delivered, and it showed as a hard depression on the mesial and anterior aspect of the bowel. Several small hard lumps were felt in the bowel above and below the growth. At first I thought these were secondary growths, but I was able to crush some of them between my fingers and to move others along. The liver was normal and the pelvic peritoneum was normal. There were a few enlarged glands in the mesentery behind the growth. I divided the parietal peritoneum to the left of the growth and several inches away from it, and thus liberated the colon. I then brought a long loop out of the abdomen and protected the wound with two layers of packs, and clamped the base of the loop with one long clamp, after tying the vessels in the mesentery with two strong linen threads. The loop was then removed between the two clamps, and an end-to-end union was made with fine black thread in two continuous layers. In addition to this some appendices epiploicæ were tacked over the line of union, and the rent in the mesentery behind the anastomosis was closed with fine black thread. The bowel was then pushed back and covered over with small intestine and great omentum. The abdomen was closed in layers in the usual way. The patient stood the operation well. He was infused two pints during it. Several large glands were removed together with the bowel. It was noticed that the posterior longitudinal muscular band was very hard, but it was thought to be hypertrophied only. This was felt above and below the growth for several inches. The patient was quite well a year later.

An "L.O.A." on a Summer's Day.

Descent! my word, no doubt of that, as crashing to the floor
Come Occiput and Sinciput—the *Occiput* before!
He knew that sloping pelvic floor would cause him to rotate—
Dodged underneath the Pubic arch—Miss Sinciput was late!
Old Force-of-Ut, in furious rage, drove Vertex, Fore, and Face,
And roared with glee to see those three dash out at such a pace.
Then head pops out, and peeps about, to see what he can find,
But getting bored, the right shoulder gives him a poke behind,
And turning, beckons to his pal to hurry up and come
And don't be late (no need to rotate), those two, they do have fun!
But while they're slithering up and down, and holding their sides for joy,
A *great big hand* just picks them up—and "Mother, this is *some* boy."

The Treatment of Gunshot Wounds by Packing with Salt Sacs.

BY MAJOR A. J. HULL, F.R.C.S.

THE treatment of septic wounds by a pack which is allowed to remain in the wound for several days is so opposed to the usual teachings of surgery that at first sight its utility may be doubted. Nevertheless, such treatment has proved one of the most effective methods of dealing with septic wounds during the present war. It has also been found to be one of the most generally applicable procedures for the treatment of secondary hæmorrhage. It possesses the great advantage of simplicity, an important factor when large numbers of cases require the attention of a limited staff. It also allows transport to be undertaken without any anxiety regarding the dressing of the wound.

When it is necessary to drain a wound cavity, three methods are available. The ideal method would be to expose the whole of the interior of the wound so that its walls become exposed and more or less flat. There are anatomical and surgical objections to this, as a rule, but it is occasionally employed, for example, when a rectal fistula is slit up, when an amputation is performed by the guillotine method, and in certain cases of excision of wounds. Very inferior to this ideal method is the drainage of every pocket and cavity of a wound by drains. The interior of the wound is often very irregular, and it is sometimes impossible to ensure that every pocket is drained. The third method, treatment by solid salt, imitates the first or open method, by draining every portion of the surface of the interior.

The treatment of septic wounds must fulfil certain requirements. The infecting microbes must be removed by some form of lavage. The outflow of lymph must be increased. The bacterial growth must be repressed and the coagulation of the discharge must be prevented. The tissues of the wound must not be damaged either by chemical or mechanical measures. It is common ground that free exposure of the infected tissues must be made in order that adequate drainage be obtained, but many opinions are held as to the correct method of dressing the wound. These requirements may be met by the use of hypertonic solution of common salt.

It can be demonstrated experimentally that the higher the concentration of salt the greater will be its power of attracting water and albuminous substances. The "drawing" power of salt has been known for many years. Sir A. E. Wright's original lymphagogic solution consisted of a 5 per cent. solution of common salt mixed with 0·5 per cent. solution of sodium citrate. Early in the present war Sir A. E. Wright recommended the hypertonic solution of salt for the purpose of lavage and repression of the bacterial organisms of septic wounds. Colonel C. B. Lawson invented tablets of compressed salt which he placed in the lumen of drainage tubes. Colonel Gray, C.B., originated a modification of Sir A. E. Wright's hypertonic treatment by introducing the use of solid salt in the form of tablets. The tablets wrapped in gauze formed a solution of salt.

Packing wounds with gauze impregnated with concentrated salt solution must not be confused with the plugging of wounds with ordinary dressings. Wound cavities are only potential spaces, and in order to drain them the walls must be kept apart. Ordinary drainage tubes rarely drain every recess, and elaborate methods are required to obtain drainage from every portion of the walls and avoid the shutting off of pockets. A wound cavity filled with gauze and salt may be considered as effectively drained as if the cavity were inverted and the walls dressed as a surface wound. Every portion of the surface area is drained by the osmotic action of the salt, and the capillary action of the gauze and bandage is continually removing the discharge and producing a continuous and automatic drainage and lavage of every portion of the interior of the wound.

The tablets of salt must not come in contact with the tissue or sloughing will often ensue. The wall of the cavity must be well protected by gauze. The solid salt sac is an improvement upon the tablets. It consists of a two-walled sac of suitable size made of bandage, between the layers of which four layers of gauze are placed. The interior of the sac is filled with salt and the tail of the bandage forms a drain.

The sac is made by laying a strip of open woven bandage about a foot in length flat on the table. On this strip four layers of gauze are placed the same width as the bandage, but about 4 inches in length. On top of the gauze another strip of bandage is placed. The sides of the bandage strips are then brought together by doubling the bandage in its long diameter and sewing to form a sac. The sac is filled with salt, a few stitches are put in to close the mouth. These sacs are made in several sizes, sterilised in an autoclave, and stored ready for use. One or more of them are used to pack the wound, the intervals between the sacs being filled with gauze. A tube of perforated zinc or rubber may be passed into the depth of the wound in cases of large septic wounds. Long slender sacs are made to fill bullet tracks. Small sacs are made for draining tracks in the brain. The free end of the sac is passed into a vessel containing saline solution, and the wound then drains

by capillary attraction. A fine rubber tube may be run in along each sac, and drip irrigation carried out if required. The salt remains undissolved for several days, and when the sacs are removed from a wound at the end of a week undissolved salt still remains.

The frequency with which wounds are dressed very often depends upon empirical convention rather than on a scientific or clinical reason. Wounds are often dressed without any clear idea of the reason for removing the dressings. A dressing sticking to a wound is frequently torn off, tearing delicate granulation tissue, undoing the healing of the wound, and exposing raw surfaces for septic absorption. A more unscientific treatment cannot be imagined. In some cases, it is said, the wound is dressed in order to remove the discharge. This is simply an admission that the dressing has been acting like a cork in a bottle. A rise of temperature is another reason given for removing a dressing, but if the wound is being properly treated, changing the dressing will not lower the temperature.

There are two ways of dressing a wound so that no harm is done by the changing of dressing: one is to keep a light dressing continually moist so that its removal is not felt by the patient and no tissue is damaged; the other is to leave the dressing until it is quite moist and can be removed without pain. The dressing of deep wounds is too often merely a ritual, the dressings and drainage tubes are removed and replaced by clean ones, but the complicated series of recesses which make up the interior of most wounds cannot be reached. They may be reached by irrigation, but some portion of the wound will escape the distending effect of a drainage tube, and the walls will fall together and a pocket will result.

The effect of the salt sac is to form a concentrated solution of salt which promotes the resolution of inflammatory induration and aids the separation of dead tissue by solution of coagulated lymph. A powerful outgoing stream of healthy lymph is produced which carries microbes and débris out of the wound and retards the bacterial growth within it. It is unnecessary and undesirable to continue the action of this hypertonic solution of salt once the wound becomes clean. If the wound is clean the sacs are removed in from five to ten days and treatment by normal saline instituted. If the wound is foul it is either again packed with salt sacs or dressed every 48 hours with gauze soaked with 20 per cent. salt solution. When the patient's temperature remains high and his general condition is unsatisfactory, it is fair to assume that a streptococcus is present. The presence of healthy lymph induced by the salt sacs does not aid in dealing with the streptococcus, but it appears probable that the most effective defence the body possesses against this organism is the white blood corpuscle. When normal saline is used, the wound, hitherto bright red, becomes covered with a grey film. This is caused by the protective layer of leucocytes which act as a barrier against further invasion until the healing is completed by the ingrowth of epithelium. The hypertonic solution is, therefore, changed to normal saline when streptococcal infection appears probable.

The advantage of a dressing which does not require attention for seven or eight days will be obvious. The patient is saved the pain and inconvenience of frequent dressing, there is a diminished risk of secondary infection, and there is an enormous saving in material. The salt sacs have been found useful in many special instances. They were first devised for the drainage of septic wounds of the brain. Exceedingly septic wounds of the orbit with destruction to the eye have been treated by salt sacs after removing the orbital contents and removal of loose septic fragments from the bony wall of the orbit, with uniformly satisfactory results. Cases of secondary hæmorrhage associated with septic comminuted fractures of the upper part of the shaft of the femur have been packed with salt sacs. No recurrence of hæmorrhage took place, and when the sacs were removed eight days later, a clean granulating wound remained. The removal of a septic foreign body, whether bullet, shell fragment, or shrapnel, is only the beginning of treatment; a septic cavity and track remain which may prove very difficult to drain and dress effectively. It has become our routine treatment simply to wash out the cavity and pack with salt sacs. The soft nature of the sacs, if they are dipped into water before insertion, makes it very easy completely to pack a cavity. The sacs accommodate themselves to the size and shape of a cavity, and it is rarely necessary to add gauze to the packing. Large septic cavities associated with fracture require a drainage tube to be inserted among the salt sacs.

The dressings become somewhat offensive at the end of a week, but the odour appears to be quite harmless. The addition of the powder eupad (hypochlorous acid) to the sacs would obviate the smell, but if the smell of the drainage causes the patient to be given what is practically open-air treatment, its inconvenience will be more than compensated for.

I think it will be admitted that a method of treatment which saves the patient the pain and inconvenience of frequent dressing, which forms an efficient method of preventing hæmorrhage, and saves an enormous amount of labour and material, is a good method provided its results are equal in all respects to other methods of treatment. I consider that the results are not only equal to, but better than, any other known method, provided the technique is properly carried out. It appears rational to add an antiseptic to the salt in foul cases, and eupad appears to be the most useful. Its addition certainly appears to do no harm in my experience, and my only reason for not using it as a routine treatment is that the

plain salt gives such excellent results that it appears unnecessary. The offensive odour of the wound may in a great measure be obviated by its use. Sacs filled with eupad and salt in the proportion of one to three are destroyed in the autoclave owing to the corrosive action of the hypochlorous acid upon the fabric. A convenient method of combining the eupad with salt is to pack the wound with ordinary salt sacs sterilised in the autoclave and introduce into the middle of the sacs, without touching the wound, an unsterilised sac filled with eupad.

Six days may be said to be an average time for the sacs tc remain in the wound. The temperature usually falls to normal within that period, and a rise of temperature is apt to follow dressing the wound. This rise of temperature can usually be avoided by irrigating the wound for some hours before removing the salt sacs.

The successful results of this treatment largely depend, as all treatment of septic wounds must, upon an early campaign against the sepsis and upon the thoroughness with which it is possible to remove septic and necrosed tissue.

Appointments.

R.N.V.R.

Surgeon-Probationer—St. George B. Delisle Gray has been appointed to H.M.S. *Staunch*.

M. F. Hopson has been appointed Dental Surgeon for temporary service.

Territorial Force, R.A.M.C.

Home Counties Field Ambulance.—Captain G. W. C. Hollist, from Casualty Clearing Station, to be Captain.

Welsh Field Ambulance—Major A. R. Wilson, from Attached to Units other than Medical Units, to be Major.

Major A. R. Wilson to be Lieut-Colonel.

Civil.

R. Hedden, L.R.C.P., M.R.C.S., has been appointed Certifying Surgeon under the Factory and Workshops Act for the Honiton Division of the County of Devon.

R.A.M.C.

The following appointments have been made:—

To be temporary Lieutenant—A. A. Greenwood.

Temporary Lieutenants to be Temporary Captains—A. S. Seabrooke, F. W. Stone, C. Gibson, J. H. Jones, C. T. Hilton, J. S. Bookless, G. E. Lockyer, E. E. Frazer, C. E. Price, G. S. Miller, C. Coventry, F. W. Rowland, E. W. Blake, W. J. Harris, B. Jones, G. H. Russell, J. Dixon, H. L. Attwater.

Honorary Lieutenants to be Temporary Lieutenants—G. N. Mottram.

Canadian Army Medical Corps—Lieutenants to be Captains—H. E. H. Tracey, T. G. Evans, T. L. Jones, W. Reynolds, H. M. Gray, H. Joslem, L. W. Evans.

Temporary Captain E. A. Evans relinquishes his commission on account of ill-health.

Roll of Honour.

Killed—Fleet-Surgeon W. J. Bearblock, R.N., H.M.S. *Invincible*; Surgeon G. Shorland, R.N., H.M.S. *Invincible*.

Honours.

The following awards to Medical Officers, either for services rendered in connection with military operations in the Field, or for valuable services in connection with the War, are announced in the list of Birthday Honours issued last week.

To be C.B. (Military Division)—Colonel R. H. Luce, T. F. Res.

To be C. M. G.—Lieut-Col. L. Humphry, R.A.M.C.

D.S.O.—Major H. V. Bagshawe, R.A.M.C., and Major (temporary Lieut.-Col.) A. C. Osburn.

Mentioned in Despatches.

The names of W. E. S. Digby, and C. E. S. Watson, of the West African Medical Staff, are mentioned in Despatches from Major-General S. C. Dobell and from General Cunliffe, dealing with the operations of the Cameroon Expedition.

Papers by Guy's Men.

H. C. Cameron, M.D., F.R.C.P.: Osteogenesis imperfecta.—*Proceedings of the Royal Society of Medicine*, April, 1916.

H. C. Cameron, M.D., F.R.C.P.: Skeleton from a case of osteogenesis imperfecta.—*Ibid.*

R. O. Moon, M.D. Oxon., F.R.C.P. Lond.: Typhus fever in Serbia (Chadwick Lecture II.)—*Lancet*, June 3rd.

J. Howell, M.B., B.S. Lond., F.R.C.S. Eng.: Demonstration of surgical cases at the Cheltenham General Hospital.—*The Clinical Journal*, June 7th.

R. O. Moon, M.D. Oxon., F.R.C.P. Lond.: Typhus fever in Serbia (Chadwick Lecture III.)—*Lancet*, June 10th.

H. M. Page, F.R.C.S. Eng.: Spinal anæsthesia, with reference to its use in the Trendelenburg position, and for the prevention of shock, with a note by Harold Chapple, M.C. Cantab., F.R.C.S. Eng.—*Ibid.*

The Evelyn News.

Circulation five times as large as that of any old newspaper published under similar difficulties—probably ten times or so, but we would cease publication rather than jeopardise our reputation for modesty by false claims.

Vol. I., No. 1. WEDNESDAY, JUNE 14, 1916. Price: What we can get.

BUSINESS NOTICES.

Subscription Rates—One Year:

Three eggs, five bananas, jam in lumps, or daily supply of screens. (Sunday's eggs will not be accepted after Tuesday.)

Advertising Rates:

On application to Ex. No. 5, if you can find him.

Contributions:

The Editors welcome any attempts, however feeble, to contribute to the columns of the E. N., but will not be responsible for the return of rejected manuscripts unless accompanied by stamped addressed envelope, and 5s. to cover expense of booking. (Mem. —This "booking" stunt is a bit of a wash-out, but the fact is the Editorial Staff want your money, and are prepared to return manuscripts all day long at 5s. a time.)

OUR NOBLE SELVES.

For many years past the inmates of Evelyn Ward have felt the need of a journal through the medium of which they could express their opinions (for what they are worth), their ideas (when they have such things), and their instructions to the surgical and nursing staffs for treating each patient's complaint. It will be obvious to any attentive student of patients' conversations that the staffs mentioned are to all intents and purposes a superfluity, except in so far as they may be qualified to carry out a patient's directions for his treatment. We feel that it would be unfair to call attention to any particular instances, but from our observation of the behaviour of many patients and our personal knowledge of their freely-(not to say foolishly) expressed ideas, we would sum up by saying that nobody can possibly know better than the sufferer the nature of his complaint, the best method of dealing with it, the drugs he should take (and/or refuse), the right time to get up and the right time to go to bed. Failing the recognition by the surgical and nursing staffs of these obvious truisms it must be positively laid down that no responsibility for complications can be accepted by any patient whose instructions or wishes are disregarded by the staff.

In conclusion, we would remind our numerous readers that we are pleased at all times to receive from them any ideas, suggestions, criticisms, etc., emanating from what, in their flights of fancy, they may call their brains. It should, however, be clearly understood that in printing the effusions of any misguided individual who may write us for publication, we accept no responsibility for his opinion, his method of expressing it, or—his life.

EVELYN DAY BY DAY.

Diary of a Patient, No. 6.

a.m.

5.0. Plaintive cry for nurse, situation saved by timely arrival of chain gang.

5.15. Wash; a wholly unnecessary operation.

6.0. Chain gang; parade for spit and polish duty.

7.0. Newspapers; discussion on strategy and hopeless idiocy of Kaiser. "How to End the War next Week," by the Evelyn Expert.

7.30. Bed made; first reprimand of the day.

8.0. Arrival of day staff radiant in smiles and clean linen. Sister walks through ward with early morning air.

8.15. Offer ribaldry to staff; severely reproved.

9.0. Sister visits every patient; heart tremor.

10.30. Cards; much cheating by other fellows; I lose.

12.0. Dinner, and high time, too.

p.m.

1.0. Reproved by Sister for throwing matches on lawn; another heart tremor.

2.0. Visitor arrives; V.A.D. lady whose opinion of staff unprintable.

3.30. Not having spoken for five minutes, accused of sulkiness by nurse, who threatens ejection from hospital.

3.45. Tea; borrow jam and eggs.

5.0. Feeling fed-up.

6.0. Still more fed-up; wish I had gone to Bart.'s.

6.30. Retired to bed.

7.10. Bed made; reproved.

7.20. abused.

7.30. threatened.

7.40. Sister arrives; severe heart tremor.

7.45. Evening Service; sing lustily; effects spoilt by weird female noises.

8.0. Sister's visit; another heart tremor, followed by collapse.

8.1. Silence imposed.

8.2. Nurses commence to make as much noise as possible.

8.15. Much laughter from behind screens; ears pained by queer anecdotes.

9.2. Nurses' Committee Meeting starts.

9.30. Meeting breaks up in disorder.

9.45. Prepare to sleep.

10.0. H.-S. visits nurse; animated conversation.

11.0. H.-S. continues conversation with nurse; most interesting.

12.0. H.-S. still at it.

12.15. Turn over for first time; frightens H.-S. away.

1 a.m. Sleep. Quant. suff.

Costumes by West.

"I never saw a better-fashion'd gown,
More quaint, more pleasing, nor more commendable.
Belike, you mean to make a puppet of me."

In pre-war times, as all our readers know, the crowning pleasure of Christmas at Guy's was the long succession of topical plays presented by the Residents of the day. To an appreciative audience the words "costumes by West" were looked for as an expected item of the programme. To clothe the heroes of the play, professional stores could be drawn upon, and they duly appeared in hired and gorgeous array, but with true artistic sensibility the charm of local cut and colour was reserved for the long line of heroines in uniform. Whatever of mirth and kindly derision was provided for our delight, the greatest joy of all was to see our House-officers with waists of Milo-like proportions, hitherto successfully hidden by Norfolk jackets, strides that threatened the continuity of lilac skirts, and with voices gruff or quavering that belied the wearing of well-tied "strings" or a Sister's cap.

We remember a certain fair "Lucy" who made a great hit by appearing in grey dress, cloak, and bonnet, and most effectively small feet, and with frills and furbelows that must have been washed in Maze Pond as they are strictly forbidden in Guy's laundry. We more than suspect that the harassed playwrights had each year to meet with great importunities from would-be heroines for a part.

To look like one's ideal nurse for an evening! Let another be cast for Sir Arb.

Now much of the pleasure that comes from mutual interest in the perchance trivial and familiar things of everyday life was made possible in our hospital plays by the services of Miss West, the hospital dressmaker. Many are the costumes she has made for the "Niggers" and the Theatricals.

Towards Christmas time it was often possible to hear the request "I say, be 'in' for me for a bit; I'm going to be 'fitted.'"

Miss West's large clientele will hear with regret that her services will no longer be available when that long-looked-for Christmas arrives with another Guy's play.. All will, however, wish her happiness in her well-earned leisure when she retires this month after 26 years' service. During that time she has had charge of the hospital work rooms, where numerous articles are made for the wards and all the uniforms for every grade of woman worker.

We learn that the hospital authorities greatly regret her departure, for as an exceedingly economical manageress she has had the interests of the hospital at heart.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

The Pathology of Tumours. By E. H. Kettle, M.D., B.S. Lond. Pages viii. + 224 (126 illustrations). Demy 8vo. (H. K. Lewis & Co., Ltd.) Price 10s. 6d. net.

This book does not bring forward a great amount of new matter on the pathology of tumours, but sets out the recognized teaching on the subject in a concise and convenient form.

The volume is divided into three parts, viz., Biology, General Pathology, and Special Pathology relating to tumours. The first part is very interesting and full importance is given to dissemination, etiology and the experimental study of cancer.

It is pleasant to see Sampson Handley receiving full recognition for his very valuable work on the dissemination of cancer of the breast.

In a short chapter on Treatment the author discusses the rapid method of diagnosis of malignant growths by means of frozen sections "made on the spot," and although realizing the value of this method, he very rightly lays stress on the dangers and disadvantages of relying on its results in those difficult borderland cases of atypical carcinomata and sarcomata.

In the second part of the book Dr. Kettle describes the well-known classifications of Powell White and Adami, but relies upon the older method for purposes of description.

New growths are divided mainly into two great groups —Connective Tissue and Epithelial Tumours, which have sub-headings of malignant and non-malignant. Then follow four small groups not included in the above, viz., Endotheliomata, Hypernephromata, Melanomata and Teratomata.

The descriptions of the various growths are clear and concise, and there are numerous plates illustrating the more common types. These are good and are well arranged, so that in the majority of cases the illustra-

tion faces the descriptive letterpress—an arrangement which makes the reading easier.

In Part III. the various systems are treated and the tumours common to the parts are mentioned and the pathology special to it is discussed.

The format of the book is good and the matter is well arranged. The index is full and has the advantage of having the principal reference in heavy type.

It is hardly a book for the beginner, but we can recommend it to the more advanced student as a sound and most useful volume.

Practical Points in the Diagnosis and Treatment of Heart Disease. By E. M. Brockbank, M.D., F.R.C.P. (Messrs. H. K. Lewis & Co.) Price 3s. 6d. net. 120 pages.

This small book deals about equally with the practical and the theoretical side of heart disease, and may be recommended to students who are entering the medical wards for the first time, as it links up what they have learnt about the heart in physiology with the clinical features of heart disease as seen in the wards.

The practical side is mainly comprised in two chapters, one on the routine examination of a heart case, and one on treatment. The former is very comprehensive and quite as good, if not better, than similar chapters in other books on clinical medicine. The chapter on treatment contains nothing very striking.

The author deals very fully with the theories of the physical origin of the heart sounds and murmurs. Here his views, especially on the subject of mitral pre-systolic murmurs are not always those usually accepted.

Though a considerable part of the book deals with heart sounds and murmurs, great stress is laid on the fact that the condition of the heart muscle is the really important point in prognosis and treatment, and the student is specially warned that a loud murmur does not necessarily mean a badly damaged heart.

Surgery in War. By Alfred J. Hull, F.R.C.S., with preface by Sir Alfred Keogh, K.C.B., M.D. 26 plates and 55 text figures. (Messrs. J. & A. Churchill.)

This work, as fully explained in the preface, forms a welcome summary of the surgical experiences and conclusions of this war by one who has seen the present campaign from its beginning to the present date. There is much which is new and suggestive and will be read with interest both by those about to enter the fields described and those who have their own personal experiences to put forward in comparison.

The author does not profess to have written a complete account, but only with the view that the divergence is so great between text-book symptomatology and treatment and the cases met with in the service that the surgical knowledge of the reader being presupposed, the information provided may aid him in his adaptation to new conditions of activity.

Serums, Vaccines, and Toxins in Treatment and Diagnosis. By Wm. Cecil Bosanquet and John W. H. Eyre. Third edition. (Messrs. Cassell & Co., Ltd.) Price 9s. net.

Since the appearance of the last edition of this valuable little book so much fruitful advance in diagnosis and treatment has been made that an exhaustive revision of its contents has been thought necessary and has entailed an addition of nearly one hundred pages of new matter.

The inclusion of the field of Chemiotherapy, though it may appear illogical in such a volume, is found welcomely present, since there is much fundamental identity between the lethal action of arsenical compounds and dyestuffs upon protozoa and the action of specific serums on bacteria.

Lessons from the war are advisedly included and valuable information provided.

The book is excellently written and produced and replete with concise and condensed descriptions and directions of work in the newest and one of the most important fields of medical therapeutics.

Marriages.

SANER—DENOUX.—On the 31st May, at Brompton Oratory, S.W., John Godfrey Saner, M.C. Cantab., F.R.C.S. Eng., to Fernande Gabrielle, daughter of the late Monsieur Denoux, and of Madame Denoux.

WYATT—BRIGGS.—On May 31st, at St. James's, Piccadilly, H. D. Wyatt, M.D., of Green Lanes, Godalming, to Gertrude May Briggs, Widow of Charles Briggs, of Norwood.

Death.

ELLIMAN.—On June 3rd, at Bella Vista, San Remo, Italy, Arthur Charles Elliman, M.R.C.S., L.R.C.P., aged 50.

F. A. K.

GUY'S HOSPITAL GAZETTE.

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Passim.

ONE fog has lifted and left us with a reasonable condition to view and absorb our own surroundings and future, for have not the Central Committee delivered their ultimatum and shown us all we have to do with them, and all they intend to do with us? It is now all down in hard, cold, printed statements—but there is still another cloud, and one which concerns us at home really more closely in these days of personal sacrifice. It is the doubt and uncertainty we feel for the safety of our many friends whose letters we address so easily to the B.E.F. Such crisis and such activity appear darkly imminent that we feel their weight and obscurity more than anything we have previously known, and we at home can only fervently hope for the best of good fortune for the many good fellows who were among us in the happy days of peace.

WE have received the Guy's Hospital Annual Report, 1915, and find that in the current issue it has been thought advisable to omit some of the formerly familiar features. Attention is drawn to the absence of slackening in the work of the Hospital and the heavy expenditure inevitably incurred, the income of the past year being exceeded by a considerable sum and the hope expressed that this condition of affairs will stimulate the generosity of all who have the welfare of the Hospital at heart.

The Governors deplore the loss by death of four of their colleagues, namely, Mr. Chas. H. Goschen, General E. H. Clive, Capt. the Hon. H. H. Molyneux and Mr. C. R. G. Hoare. Sir Geoffrey Cornewall, Bart., and Mr. Almeric Paget have been elected to the Corporation.

Mr. W. Brailey, Consulting Ophthalmic Surgeon, and Mr. Clement Lucas, Consulting Surgeon, have died during the year. Dr. Frederick Taylor, Consulting Physician to the Hospital, has been elected President of the Royal College of Physicians.

With a Staff depleted of nearly half its number, the Governors gratefully acknowledge the help that has been afforded by members of the Consulting Staff, and the readiness with which extra duties have been undertaken by all concerned.

Turning to the statistical side, it is noticed that although the average number of patients in daily attendance has somewhat risen, the total number of In-Patients has decreased slightly, and there is some increase in average length of stay in Hospital.

This unexpected result is undoubtedly due to the use of Stephen Ward as an Officers' Section, where many cases have required extremely prolonged treatment, and the diminished number of medical beds.

Probably as a result of increased income in many poor families due to war conditions there is a further small decrease in the number of Out-Patients in almost all departments, and it is noticed also that more threepenny payments have been taken at the Dispensary.

With a diminishing staff the attendance of Medical Out-Patients on Thursdays and Saturdays is temporarily discontinued.

From the Nursing side it is seen that during the year 137 Probationers began work in the wards and 22 ladies joined for short periods of training in special work, while a very large number of Nurses, trained at Guy's Hospital, are engaged in the Military and Naval Nursing Services.

The Massage Department, re-organised in December, 1914, has admitted non-resident pupils to the number of 61, under a specially qualified Sister, associated with a Staff Nurse. During the year treatment was given to 25,222 patients.

The Accounts for the year are given and show an unwelcome deficiency on the Income and Expenditure Account of £4,801 4s. 1d. as a direct result of the serious rise in cost of provisions and domestic supplies, a satisfactory economy having been promoted in Surgery and Dispensing supplies. The Annual Subscriptions have been but slightly reduced and Donations largely increased, showing that the welcome benevolence of the public is excellently maintained.

In the latter part of the year the newly completed extension of the Out-Patients' Building for Tuberculosis and Orthopædic cases was brought into partial use, and the new Bacteriological Laboratories were completed and opened in February, 1915.

The staff of the Works Department has been reduced, and the number has now reached a minimum if the repair and up-keep of the buildings is to be maintained at a reasonable standard.

In all directions the aim has been for economy without in any way diminishing the Hospital's ability to aid the sick in their time of need—and we feel that the greatest credit and appreciation is due to those in whose hands the duties of administration have been placed.

THE election to the Council of the Royal College of Surgeons will take place early in July.

On Sir Arbuthnot Lane's retirement this year, Guy's is left with but two members on the Council, namely, Messrs. Dunn and Symonds. Mr. Steward is a candidate for one of the new vacancies, and it is most sincerely hoped that he will receive strong support from all Guy's fellows.

AT the Final Examination in Dental Surgery of the Royal College of Surgeons of England 45 candidates were examined in Part I. (Anatomy, Physiology, and Surgery), of whom 31 were approved and 14 rejected. Of these 45 candidates 15 were Guy's men and all were successful.

In Part II. (Dental Anatomy and Dental Surgery) 28 candidates were examined, of whom 20 were approved and 8 rejected. Of these 28 candidates Guy's share consisted of 14, of whom 13 passed and 1 failed.

Only one failure out of 29 candidates is a record that the Hospital and teachers concerned therein may well be proud of, and proclaims with marked emphasis the quality of the teaching to be obtained at this School.

A CURIOSITY appeared in the post at the Matron's office a few days ago, and although such epistles are, we believe, hardly a novelty in these days of war and loneliness, the following seems to be unique, at least in its style and environment :—

"Alton Street
Tues. 20 June.

Dear Madam

I send those few Lines just to no if you will let Me no if there is a pasient in this hopptal how have no one Bee longing to him thut would Care to corspond with Me I am a young wonon I am working I would like to settle Down if I meet a good partner would not Mind how badly he may be wonded as he would get every a care and a tendence from Me would you read this to Some poor felow how has noone to Care for him give him My address you will do me faver and you will do some poor felow good as well as you do me good.

Will you write Dear Madam By return

I remain your
Obegent Searvent,
Mary ———."

WE are glad to hear that the total subscriptions raised for the presentation to Mr. Morley, our late Janitor, have by this time amounted to nearly fifty pounds.

PUBLISHED with this number, there will be found a half-tone reproduction of a portrait of the late Sir James Goodhart. A reproduction corresponding with the Gazette series of Staff portraits was issued at the time of his retirement from the Hospital Staff.

Appointments.

Medical School Appointments.

JULY–SEPTEMBER, 1916.

Dressers and Clerks in Special Departments:—

Eye and Nervous System.—Messrs. G. W. Heckels (Mr. Eason); J. J. Conybeare, H. St. H. Vertue (Mr. Ormond).

Obstetric Dressers and Externs.—Messrs. E. H. Bryant, E. F. Deacon, J. C. C. Howe, S. W. F. Underhill, H. N. Pritchett (Mr. Bellingham Smith); J. A. Berry, L. Gill, R. Leblanc, R. S. Millar, B. Ramirez (Mr. Chapple).

Surgeons' Dressers.—Messrs. C. G. Coombs, C. H. Laver, A. Magill (Sir Arbuthnot Lane); J. R. Cox, E. C. Hinde, S. K. Wong (Mr. Dunn); A. Bulleid, L. S. Debenham, J. Victory (Sir Alfred Fripp); J. C. Gie, W. R. G. Hearnden, H. Millett (Mr. Steward).

Extension Medical Ward and Post-mortem Clerks.—Messrs. T. Fernandez, N. Kamchorn, R. C. W. Staley (Dr. Hale White); W. A. Flynn, O. Halstead, G. A. S. Shacklock (Dr. Shaw); C. W. W. Armstrong, F. Caldecott, G. Meadows (Dr. Fawcett); J. W. H. Grice, A. Y. Massouda, B. C. W. Simpson (Dr. Beddard).

Medical Ward Clerks (first three months).—Messrs. H. F. G. Berncastle, F. K. Escritt, C. Gill-Carey, C. Moffatt, A. R. Neckles, A. G. Ord, G. V. Richards, S. H. Robinson, W. H. Simmons, W. Skelly, G. M. Thomas, J. E. van der Merwe.

Assistant Surgeons' Dressers.—Messrs. H. G. Burford, W. H. Grace, S. Wolff (Mr. Fagge); A. R. Doyle, A. L. S. Payne, A. G. M. Severn (Mr. Rowlands); H. O. Long, W. H. Steavenson, F. Young (Mr. Turner); C. R. Cade, H. J. Leviseur, A. A. Osman (Mr. Hughes).

Surgical Ward Clerk.—Mr. T. G. D. Bonar.

Student Demonstrator of Microscopical Pathology.—Mr. C. W. W. Armstrong (July–December).

AUGUST–OCTOBER, 1915.

Clinical Assistants.—Messrs. E. de Robillard (Dr. Fawcett; J. F. Carter Braine (Dr. Beddard).

R.A.M.C.

The following appointments have been made:—

Temporary Lieutenants to be temporary Captains—H. Webb, F. W. Fawcett, H. D. Smart, G. Clark, E. G. Goldie, E. Coleman, L. W. Evans, W. F. Clark, M. A. Collins.

Temporary Hon. Lieutenant to be temporary Hon. Captain—H. W. Jones.

To be temporary Lieutenants—A. Davidson, D. H. A. Galbraith, J. A. Edmond, E. N. Glover, H. L. Shelton.

Temporary Lieutenant J. L. Atkinson relinquishes his commission.

Territorial Force, R.A.M.C.

Home Counties Casualty Clearing Station—Lieut. W. L. Hibbert to be Captain.

East Lancashire Field Ambulance—Lieut. A. W. Berry to be Captain.

London Field Ambulance—Captain (temporary Major) J. W. Bird to be Major. Major J. W. Bird, D.S.O., to be temporary Lieutenant-Colonel.

London (City of London) Field Ambulance—Major J. A. Masters to be temporary Lieutenant-Colonel.

Civil.

José J. Nunez Jimenez, L.D.S. Eng., has been appointed President to the Faculty of Dental Surgery of Costa Rica.

R. Orozco Casorla, L.D.S. Eng., has been appointed Dental Surgeon to the School Dental Clinic of San José.

Mentioned in Despatches.

The following names have been brought to notice for gallant and distinguished conduct in the field being mentioned in a despatch received from General Sir Douglas Haig, C.B., Commander of the British Forces in France, dated April 30, 1916:—Lieutenant-Colonel H. Hewetson, Major A. C. H. Gray, Major A. J. Hull, Major A. C. Osburn, Temporary Captain A. C. Hancock, Temporary Captain E. S. Marshall, Captain R. Montgomery (spec. res. killed), Temporary Captain J. L. Stewart, Temporary Lieutenant H. D. Smart.

In despatches received from General Sir John Maxwell and Major-General Sir A. Wilson.

Dealing with the military operations in Egypt from November, 1914, to March, 1916, the names of the following officers are mentioned:—

Major H. V. Bagshawe, R.A.M.C., A.D.M.S.

Medical Services—A.M.C. and R.A.M.C.: Colonel A. W. Hall. Temporary Colonel: A. H. Tubby.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—The kind and appreciative notice of my father's life that appeared in your last issue tempts me to beg the courtesy of your columns to amplify, if I may, the story of one episode—his retirement from active work at Guy's; for it may well be forgiven to those who knew him not if they wonder at a man allowing the mere "insistent calls of private practice" to come before his duties to his School. Indeed, as your article hints there were those at the time who thought him wrong. It may, however, be stated most emphatically that the calls of private practice were not the grounds for his decision. He knew better than anyone else how great was his debt to Guy's, and there was only one question for him to settle, how best to do his loyal duty to the School and to medicine.

Looking at the question broadly it may be admitted that the post of physician at a large teaching hospital carries with it two great advantages: first, it gives the opportunity of obtaining that wide and varied experience which must be the first essential in all consulting work; secondly, it brings its occupant into very special and intimate connection with a large number of men from whom he hopes to draw material for even wider experience later on. My father realised very fully how richly he had reaped from his eleven years' tenure, and he began to wonder whether he was justified in retaining so coveted a post. He knew the disadvantages under which the assistant physicians laboured in the lack of clinical material available; he found contemporaries at other Schools still serving their time in junior posts, and saw in their limited opportunities a grave loss to medicine; in his own hospital there was an outstanding example on the surgical side of the hardship thus inflicted. Feeling, as he did, and knowing the brilliance of his younger colleagues, it is not surprising that he had the wish to make way. Sentiment and self-interest both pulled the other way; only those who have already made their farewell can know the wrench in saying goodbye to the familiar walls and old accustomed faces, and the risk in cutting himself adrift so early from future generations of Guy's men was immense, especially so for one who had none of the gambler's instinct and to whom nature had denied at birth the gift of self-advertisement. He knew the risk; the anxious moments that it gave him were largely responsible for the complete breakdown in his health that occurred the following year, but he found it his duty to take it. He decided against himself and resigned, and I do not think that it is only filial affection that has always made that decision for me a very fine example of the simple courage and unselfishness with which he faced problems in his life.

If I may trespass still further on your space I would like to take the opportunity of sending a message to many old Guy's men whom I cannot reach in any other way. Some three or four weeks before my father died, when we had as yet no idea of the gravity of his illness, he had decided to retire from work, and it was his wish to write to all his old friends and tell them how deeply he appreciated their constant kindness through many years of friendship. Several times he began to dictate a letter, but strength failed him to complete it, and now I can only assure all those who knew and loved him that he left them with a feeling of deep gratitude in his heart and on his lips an affectionate farewell. To all those who have written in such numbers to my brother and myself, especially to those who have not yet heard from us, I would also add our very grateful thanks; the striking testimony to the affection that they gave him will ever be one of our proudest memories.—I am, Sir, Yours very truly,

GORDON W. GOODHART.

24, Warwick Gardens,
Kensington, W.
June 24th, 1916.

DEAR SIR,—I enclose you a cutting from the paper as to the estate left by an old Guy's man better known as George Coombe. He was in practice at Southport for some years and then gave up medicine for politics, which he seems to have found more in his line. He qualified about 1871, and was a wonderful boxer and very quick on his legs. I have seen no notice of his death in the GAZETTE, though the daily papers had references to him.—Yours faithfully,

B. RIX.

2, Mount Ephraim Road,
Tunbridge Wells,
22nd June, 1916.

"Sir George Augustus Pilkington, former M.P. for Southport and High Sheriff of Lancashire, who died at his residence, Belle Vue, Southport, on January 28th, left estate sworn at £269,840. He left £1,000 each to the Southport Infirmary, the Southport District Nursing Society, and the Southport Provident Society; £500 to Southport Ladies' Aid Fund; and £100 each to the Southport branches of the National Society for the Prevention of Cruelty to Children, the Lifeboat Institution, and the Royal Society for the Prevention of Cruelty to Animals."

DEAR SIR,—Do you think the enclosed prescriptions from an old receipe book, dated 1746, all manuscript, that has lately come into my hands, worth reproducing?—Yours, etc.,

T. RENEIL ATKINSON.

Chadwell Heath,
Essex,
June 13th, 1916.

FROM A MEMO. BOOK LABELLED
RECEIPTS, 1746.

1. FOR A STRAIN.—Oil of Roses, Lilies, Camomil and *Wormes*, each a pennyworth. Bath'd by a fire.

2. FOR THE RHEUMATISM.—Dr. Broscholm's. Half a drachm of the powder of Crab's Eyes and Crab's Claws every morning.

3. FOR THE STONE OR GRAVEL.—One pound of Antimony powdered put into seven galloons of Middle Bear; put it into a bag and hang it on a string in the middle of the vessel. Let it hang a week and take half a pint fasting in the morning and at 4 o'clock in the afternoon.

4. FOR DAUGHTER, WMSON'S CHOLLICK.—About half an hour before you go to bed twenty-five drops Laudarnum and twenty-five drops of Tincture of Castor. Take care to keep your body soluble.

5. MRS. COCKBURN'S RECEIPT TO GIVE A STOOL OR TWO NEXT MORNING.—Take Æthiop's Mineral Antimone in fine powder each an ounce, Venis Theriacal half an ounce, Syrup of Orange Peals as much as will make an electuary. To take the bigness of a nutmeg going to bed.

6. TO LAY ON YOUR HEAD.—About one-third of Tallow melted, then put in three-thirds of Burgundy Pitch.

7. TO MAKE MRS. LEAMAN'S WATER TO WASH OLD SORES.—Half an ounce of Camphir, half an ounce of Copperas, half an ounce of Bole Armenick. Powder them all. Take two quarts of spring water and boil it well. Afterwards put in the Camphir, Bole Armenick and Copperas and stir them till all are cold. When you use it make it hot.

8. AN APROVED RECEIPT FOR THE PILES.—Two drams of Gum Dragon dissolved in Rose Water to a pulp. Loafe Sugar two ounces finely siveted, Flower of Brimstone one ounce. Make it into past, roll it thin and cut it into what form you please, and dry them on white paper. Let the paisiont eat 4 or 5 or 6 in a day.

There are many more such, most of them too long to copy.

Papers by Guy's Men.

E. J. Spriggs, M.D., F.R.C.P.: The fasting treatment of diabetes.—*The B. M. J.*, June, 17th, 1916.

C. H. Mills, M.R.C.S., L.R.C.P. Lond. (in collaboration with L. W. Harrison, D.S.O., M.B., B.Ch.): The effect of ferrivine and intramine on syphilis.—*The Lancet*, June 17th, 1916.

G. L. Preston, M.R.C.S., L.R.C.P. Lond.: A case of Erb-Duchenne paralysis due to a bullet wound of the fifth cervical nerve.—*Ibid.*

M. S. Pembrey, M.D. and F. E. Shipway, M.D.: Observations on the influence of anæsthetics on the temperature of the body.—*Proceedings of the Royal Society of Medicine*, May, 1916.

John D. Malcolm, F.R.C.S. Edin.: Congenital cystic kidney with local diffuse peritonitis: Surgical destruction of part of kidney: Recovery.—*B. M. J.*, June 24th, 1916.

Notices.

Treasurer's Gold Medal for Clinical Medicine, 1916.

Mr. E. S. Phillips - - - - *Medal.*
Mr. J. M. H. Campbell - - *Proxime Accessit.*

The Royal Sanitary Institute.

PRIZE ESSAY ON MATERNITY AND CHILD WELFARE.

The Royal Sanitary Institute offer a prize of £50 and the medal of the Institute for the best Thesis, setting out a complete and practical scheme for Maternity and Child Welfare Work, suitable for adoption by Local Authorities.

The following among other points should be dealt with:—Ante-natal care and the means of exercising it. Child welfare from birth to school age. Formation and function of Clinics or other suitable institutions. Control in the home. Home and Institutional instruction and treatment. The utilisation of existing organisations or agencies. The qualifications and payment of officers and workers.

The scope of the Thesis need not be limited entirely by existing conditions. Originality and practicability in the scheme set out will receive full consideration.

Regard should be had to official memoranda and regulations already issued.

GENERAL CONDITIONS.

1. The Thesis to consist of not more than 6,000 words, to be type-written on foolscap, one side only.

2. Two competitors may join in sending in a Thesis.

3. The Thesis must be delivered on or before September 1st, 1916, addressed to the Secretary of The Royal Sanitary Institute, 90, Buckingham Palace Road, London, S.W.

4. The Thesis to be submitted without the name of the competitor, but with a motto legibly marked on the right hand lower angle of the first sheet; and to be accompanied by a letter containing the competitor's name and address, which is to be enclosed in an envelope sealed with a blank seal, and having on the outside "Maternity and Child Welfare Thesis, 1916," and the same motto as that attached to the work submitted. The Thesis and sealed envelope must be enclosed in another envelope, bearing the words "Maternity and Child Welfare Thesis, 1916," and the competitor's motto at the right hand lower angle, and must be directed to the Secretary, of The Royal Sanitary Institute.

5. Should no Thesis be considered of sufficient merit or importance to deserve the prize offered, the Council reserve the right of withholding the award.

6. In the event of two Theses being of equal merit, the prize may be divided.

7. The Thesis or Theses to which the prize is awarded are to become the property of the Institute.

8. The carriage to and from the office of the Institute, and all expenses incidental thereto, must be paid by the competitor. Unsuccessful Theses will be returned on application, on the production of a formal demand within a period to be specified after the close of the competition.

9. Due care will be taken of all Theses, but the Institute will not be responsible for any loss of, or damage to them while in its keeping.

Members of the Council of the Institute are not competing.

E. WHITE WALLIS,
Secretary.

90, Buckingham Palace Road,
London, S.W.
May, 1916.

The University of Cape Town with which is incorporated The South African College.

Applications are invited for admission as members of the Convocation of the above University from all persons who are qualified in accordance with the Act.

The time within which applications must be sent in and the qualifications necessary for membership of the Convocation are as follows:—

All graduates of the University of the Cape of Good Hope, who become such graduates as the result of examination, while they were students of the South African College or the Diocesan College, and who, within six months after the commencement of this Act signify in writing addressed to the Registrar of the South African College, that they elect to be members of the Convocation of the University.

All persons who have been students of the South African College or the South African College School, or at the Diocesan College, and who, prior to the appointed day, have graduated at the University of the Cape of Good Hope or some other approved university, and have been admitted to Convocation upon application thereto, and who, within six months after the commencement of this Act, signify in writing addressed to the Registrar of the South African College that they elect to be members of the Convocation of the University: all persons who, having been admitted to the ad eundem degree of the University of the Cape of Good Hope before the appointed day; and all persons who, not having been students in any University College in the Union, have, before the appointed day, been admitted to any degree in the University of the Cape of Good Hope, and who notify the Registrar of the South African College within a period of three months from the commencement of this Act of their intention to become members of Convocation.

The date of the commencement of this Act is May 9th, 1916.

Forms of Application may be obtained from

A. D. R. TUGWELL,
Registrar,
S.A. College, Cape Town.

5817my

Change of Address.

G. H. FitzGerald, from Admiralty Office, Petit Port, Boulogne, to c/o R.M. Barracks, Portsmouth.

Capt. A. C. Hancock, R.A.M.C., 27th Field Ambulance, 9th Division, B.E.F.

Lieut. R. Boswell, R.A.M.C., No. 7 General Hospital, B.E.F., France.

E. W. Goodall, M.D., from Eastern Hospital, Homerton, to North Western Hospital, Lawn Road, Hampstead, N.W.

M. Fred. Hopson, c/o Senior Dental Officer, Zanzibar.

Lieut. P. R. Boswell, R.A.M.C. Training Centre, Officers' Mess, Camp No. 5, Codford, Salisbury.

Lieut. W. S. Richardson, R.A.M.C. (T.), 46 (1/1 Wessex) Casualty Clearing Station, B.E.F.

R. Orozco-Casorla, L.D.S. Eng., San José, Costa Rica, Central America.

José J. Nunez-Jiménez, L.D.S. Eng., San José, Costa Rica, Central America.

Dr. F. G. Welchman, 25, Upper Park Fields, Putney, S.W.

W. W. Pryn, Royal Naval Hospital, Plymouth.

J. C. Newman, Surgeon, R.N., H.M.S. *Commonwealth*, c/o G.P.O., London.

Capt. Wilson Tyson, R.A.M.C. (T.), 1st Eastern General Hospital, Cambridge.

Capt. T. E. Hutchinson, 8th Field Ambulance, 5th Australian Division.

Major T. B. Layton, R.A.M.C., Capt. E. P. Minett, R.A.M.C., Capt. L. Price-Harris, R.A.M.C., Capt. G. B. Pritchard, R.A.M.C., Capt. C. E. Petley, R.A.M.C., Capt. L. Milton, R.A.M.C., 2/4th London Field Ambulance, from Sutton Vemy, Warminster, Wilts., to B.E.F. France.

Surgeon L. C. Dundas Irvine, R.N.V.R., from H.M.S. *Cornwallis* to H.M.S. *Vivid*, c/o G.P.O., London.

Surgeon L. C. Dundas Irvine, R.N.V.R., from H.M.S. *Vivid* to R. N. Hospital Ship *Plassy*, c/o G.P.O., London.

R. Gillbard, M.R.C.S., L.R.C.P., to St. Margaret's, Dean Road, Willesden Green, N.W.

(The Editor will be very glad to receive a post card with notes of any change of address.)

Gazette Special Pathologist.

A. E. L., BUCKINGHAM.—This growth is malignant and has the structure of a squamous epithelioma. It is composed of ingrowing epithelial masses with cell-nests and keratinoid changes, accompanied by inflammatory changes in the surrounding tissues.

Carcinoma of the Colon causing Intestinal Obstruction.

CLINICAL LECTURE BY R. P. ROWLANDS.

GENTLEMEN,—To-day I propose to deal with some cases of carcinoma of the colon which are too late for primary resection owing to the onset of intestinal obstruction. These are mostly cases of complete obstruction. When the obstruction is not complete the distension of the bowel can be greatly relieved by medical treatment and careful dieting as a preliminary to primary resection.

Symptoms and signs.—As a rule there is a history of constipation with occasional attacks of diarrhœa, offensive stools, flatulent dyspepsia, griping pains, weakness, wasting and anæmia, and in many cases minor attacks of obstruction have preceded the terminal one. Sometimes, however, an elderly patient, who is apparently quite well, is suddenly seized with complete obstruction; but the usual history is that of chronic obstruction terminating in acute or complete obstruction. Even when the obstruction has become complete, the symptoms do not develop with anything like the rapidity of those due to obstruction of the small intestine. Obstruction of the small intestine is from its position essentially acute and that of the large intestine subacute or chronic; but there are notable exceptions to this rule. Stricture of the small intestine causes chronic obstruction often terminating in an acute attack, and volvulus of the large intestine is usually one of the acutest forms of obstruction. When complete obstruction due to growth of the colon develops, this is often due to the impaction of a foreign body or scybalum in the stricture, or in other cases to inflammation of the growth narrowing the lumen. The pain becomes much more severe and is sometimes quite sudden in onset and associated with some collapse. The constipation becomes complete as a rule in spite of purgatives and enemata, but occasionally there are frequent small actions of the bowel consisting mostly of blood and slime, and unless the stools are examined the surgeon may be misled. Meanwhile the abdomen becomes more distended and this distension is in striking contrast to that due to obstruction of the small intestine, for not only is the front and middle of the abdomen distended, but also the flanks and loins, where there may be some dulness owing to the large amount of liquid in the colon. Vomiting is often a late symptom and sometimes only terminal. The tongue is dry and the patient complains a good deal of thirst, and generally insomnia is marked owing to frequent attacks of colic.

Diagnosis. (a) *From other things.*—It is not always easy to diagnose chronic intestinal obstruction from other abdominal conditions such as gall-stones giving rise to repeated attacks of cholycystitis associated with constipation; or repeated attacks of subacute appendicitis also associated with constipation and similar attacks of inflammation of diverticula of the colon. These conditions are usually associated with marked local tenderness and rigidity, and some pyrexia which is in striking contrast with obstruction of the colon where the abdomen is uniformly supple, not tender, and the temperature is often subnormal. Renal colic has been mistaken for intestinal obstruction. But in all these conditions opening medicines and repeated enemata are effective.

(b) *From other causes of obstruction.*—A strangulated hernia must always be considered and sought, for the sigmoid colon may be incarcerated in a left inguinal hernia. Tuberculous or malignant stricture of the small intestine is usually associated with far less distension and is at last more acute. In volvulus of the large intestine the abdomen becomes much more rapidly distended and the patient far more ill. Occasionally a gall-stone may become impacted in the pelvic colon and may be mistaken for carcinoma at this spot, but there is generally a history of repeated attacks of pain in the right hypochondrium and particularly of a recent attack of pain there associated with fever. Similarly a fæcolith may become impacted in the pelvic colon. This may be just out of reach of the finger introduced into the rectum. In one instance I was able to feel one when the patient was in the sitting position and straining. This avoided a laparotomy, for the fæcolith was broken up and removed under an anæsthetic.

(c) *Diagnosis of the site.*—In at least 70 per per cent. of cases the obstruction is below the splenic flexure. In some cases either the tumour or scybala just above the obstruction may be feelable. In other cases only the right flank may be distended, indicating that the obstruction is higher than the descending

colon, but in some cases the cæcum may be greatly distended without any appreciable distension of the descending and transverse colon, and yet the obstruction is found to be in the pelvic colon. On bimanual examination of the pelvis sometimes a growth is felt in the dependent loop of the pelvic colon, and in many instances an obstructing growth is felt in the upper part of the rectum. The sigmoidoscope is very valuable in locating the growth, and especially in old people, where resection is out of the question, colostomy undesirable, but a short circuit desirable.

Operation.—An operation is not desirable for every patient suffering from obstruction due to cancer of the colon. In some very old and especially poor patients where resection is impossible, colostomy is most undesirable, and in these cases it is better to make the patient as comfortable as possible with morphia for the short remainder of life. With a colostomy they are a great nuisance to themselves and to their relations. An *operation* should practically always begin with an exploration near the middle line. It is more convenient to make this to the left of the middle line on account of the usual position of the growth. When the growth has been found it is wise to examine the liver, aortic and iliac glands, and the peritoneum, especially that lining the pelvis, to ascertain if there is any secondary growth which would at once abolish any hope of resection. The cases may be divided into—

(A) Those in which resection either immediate or secondary is hopeful.

(B) Those in which resection is impracticable.

When the growth is movable and not invading any important viscus, and there are no signs of secondary growth, then resection may be considered hopeful if the patient's general condition will allow. Three chief ways are now open to the surgeon.

1. Colostomy above the obstructon and well away from it.

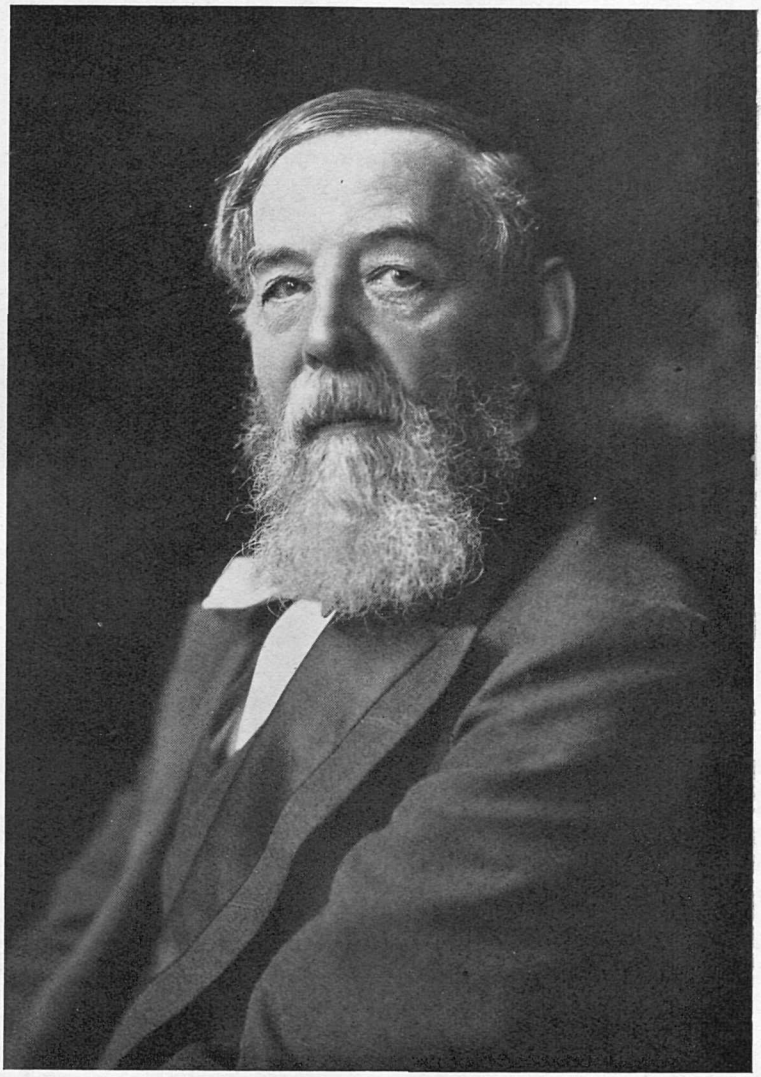
2. Short-circuiting, such as ileo-colostomy.

3. Resection with drainage after Paul's method.

Resection with complete restoration of the channel is too dangerous to adopt under the circumstances of complete intestinal obstruction.

A. 1. *Colostomy* above the obstruction and well away from it. If possible the ascending or transverse colon should be selected, for cæcostomy is not so satisfactory on account of frequent and fluid discharges. Mr, Paul, with his wide experience, advocates a right lumbar colostomy in these cases, because the opening being posterior is well removed from the site of incision for a radical operation, and he thinks it safer than an interior operation. I prefer an anterior lumbar colostomy, which can be performed easily enough after incising the peritoneum to the right of the ascending colon. A transverse colostomy is often the most convenient. An anterior incision enables us rapidly to explore the abdomen and to ascertain the cause and site of obstruction, and the presence or absence of secondary growths in the liver or peritoneum. In this way we can avoid a catastrophe in overlooking a volvulus, or an obstruction of the lower ileum, and we can at once decide if resection of a growth is likely to be feasible later on. I know of a case in which exposure of the descending and then of the ascending colon through the loin showed the large bowel to be empty. After death a gallstone was found obstructing the ileum. Colostomy is no doubt safer than short-circuiting in the presence of complete and late obstruction with intestinal paralysis, especially in old people. When the growth is near the ileo-cæcal valve, or in the ascending colon, short-circuiting is generally to be preferred, for the fluid frequent and irritating discharges from the cæcum or ileum are very objectionable.

A. 2. *Short-circuiting*, such as ileo-colostomy. This can be very rapidly performed, and it need not interfere with a subsequent resection, but, on the contrary, it often lessens the work to be done at the second operation, and thus diminishes the risk. This is particularly applicable to growths of the ileo-cæcal region. At the primary operation the ileum is anastomosed to the transverse or sigmoid colon, and a fortnight later the growth is removed and the open ends are closed, there being no need to unite them, as the channel has been already established. For these reasons, unless the patient is very ill, I prefer short-circuiting to colostomy as a preliminary to resection. In the presence of complete obstruction with paralytic distension this is not so likely to save life as colostomy, but in other cases it is cleaner and often renders the subsequent resection somewhat easier and safer. In some cases, however, adhesions form around the anastomosis, which render an early resection somewhat difficult.



Sir JAMES FREDERIC GOODHART, Bart.,

M.D., LL.D., F.R.C.P.

BORN 1846. DIED 1916.

CASE 1.

Carcinoma of the Sigmoid. Acute Intestinal Obstruction. Anastomosis of the Ileum to the Pelvic Colon. Secondary Resection. Recovery. Secondary Growths in Liver after four years.

MRS. D., aged 61. A patient of Dr. Brookhouse, of Bromley. The patient first consulted Dr. Brookhouse for vague abdominal pains on January 11th, 1910. Dr. Brookhouse examined her carefully and failed to discover any abnormality. The patient said that she had had indigestion and pains in the abdomen since about August, 1909. She looked very well. There was no history of the passing of blood or mucus. The bowels were irregular and practically always constipated. The patient was seized with more severe pain on the morning of May 8, 1910. Since then the bowels have not been satisfactorily opened in spite of opening medicine and enemata. Three small lumps only were brought away on the 9th. The patient has had nothing but water by the mouth since the onset of the pain. The pain is very severe and of a colicky nature. It seems to be worse on the right side of the abdomen where Dr. Brookhouse found a distended piece of bowel, probably the cæcum. He was not able to find any visible peristalsis, but on putting his hand upon the distended part a gurgling noise passed across the abdomen towards the left flank. Nothing abnormal could be found on rectal examination. The temperature was 99°. The patient was not sick once, but there was no inclination for food. The tongue had become increasingly dry. When I saw her on May 11, about 6 o'clock, the abdomen was generally distended. This was more marked in the right flank. No shifting dulness could be made out, and no tumour. The pulse was about 100, good and regular. The patient's general condition was fairly good.

Operation.—The abdomen was opened through the lower part of the right rectus. The cæcum was found to be distended with fæces, and the small intestine was congested and slightly distended. A growth was found in the descending limb of the sigmoid loop. It was large and congested, measuring about three inches long, and it was constricted at the middle. The bowel below it was quite empty. This was brought into the wound, and a lateral anastomosis was made between it and the ileum, six inches from the cæcum. The opening in the pelvic colon was placed as low down as possible, about four inches below the growth, in order to allow plenty of room for a secondary resection later on.

For the first ten days after the operation the bowels opened freely from eight to nine times a day. Later the bowels acted very comfortably and regularly once a day.

Second Operation.—June 26th resection was performed at the nursing home. The abdomen was opened through the lower part of left rectus. There were a good many adhesions in the pelvis and on the right side of the abdomen, especially near the old incision. The ileum above the anastomosis had dilated and thickened to a considerable extent. No secondary growths were felt in the liver or in the lumbar, mesenteric, or iliac glands. The growth which had got considerably smaller since the first operation, and the anastomosis were adherent to the parietal peritoneum on the brim, and also to the left ovary which was grey and suspicious looking. The left tube and ovary were removed, and an incision was made in the parietal peritoneum to the left of the sigmoid. This rent was enlarged and the sigmoid was freed by gauze dissection until the iliac vessels and the ureter were seen and displaced backwards. The ovarian vessels were tied and divided. The descending colon was freely mobilised and gauze packs were passed into the pelvis and behind the growth in the iliac fossa and the left loin. A large gauze roll had been used earlier to keep the small intestine from the seat of the operation. The abdominal wall was carefully protected with gauze. The bowel was clamped four inches above and two inches below the growth. An attempt was made to find the vessels in the mesentery, but the latter was so laden with fat that they could not be identified. A large Moynihan forceps was used to clamp the mesentery in an oblique manner. One blade was made to pierce the mesentery close to the bowel at the upper line of proposed section, and was passed obliquely downwards and inwards, care being taken to avoid the ureter and the superior hæmorrhoidal artery. Two supple clamps were then applied across the bowel one inch below and above the two clamps already mentioned. The bowel was then divided three-quarters of an inch above the lowest clamp and three-quarters of an inch below the upper one. The mesentery was also divided, and the loop of bowel containing the growth was thus removed, clamped at both ends. The open ends of the bowel were carefully cleansed and swabbed over with an antiseptic lotion and covered with gauze, while the rent in the mesentery was sutured with linen thread. When this had been nearly closed, the mesenteric clamp was removed. A little bleeding ensued from a vessel which had been missed by the suture. An end to end union was then made by a direct suture, the latter half of the circle of sutures being passed after Connell's method. The circle was completed at the free border, and the knot was placed inside the bowel. A sero-muscular suture was then used for reinforcing purposes, and also large appendices epiploicæ were used to cover the suture line. There was a great deal of oozing from the iliac fossa, and there was some free fluid in the peritoneal cavity at the beginning of the operation. It was, therefore, decided to drain the abdomen at the lower corner of the wound, which was otherwise closed in layers in the usual way. The operation lasted nearly two hours, but the patient bore it well and was not suffering from shock late in the evening. On the fourth day the temperature went up to 102°, the bowels were opened about twenty-five times, and some fæcal matter appeared in the wound. The abdomen was mobile and not distended. The temperature and irritability of the rectum soon subsided. The patient recovered completely in spite of a troublesome fæcal fistula which closed spontaneously. She was quite well three and a half years after the resection, but she died of secondary growth of the liver about nine months later.

A. 3. i. *Resection with drainage after Paul's method.*—Another method, especially applicable to the pelvic colon, is to bring the affected coil outside if this be not too tied down by adhesions. The vascular peritoneum to the outer side of the colon may also be divided and the colon sufficiently mobilised. It is generally easier to deliver the growth through a separate opening directly over it. When the abdominal wound

has been almost completely closed and protected with dressings, the growth can be rapidly removed and two Paul's tubes tied in, or the mesenteric two thirds of the bowel can be united and a single Paul's tube fixed in a water-tight manner in the remainder. Later on as the colon inevitably retracts, kinking diminishes and the channel may be re-established without the need of a secondary operation.

CASE 2.

Carcinoma of the Pelvic Colon. Complete Obstruction. Excision after Paul's Method.

Man, aged about 65. The patient was in a medical ward for six weeks. He was watched and examined in various ways. The abdomen was very distended, and a diagnosis of growth of the iliac colon was made.

Operation on April 16th, 1915.—A vertical incision was made through the left rectus low down. A growth was found in the upper part of the pelvic colon. The liver and pelvis were free. No glands were enlarged. The growth was freed by dividing the peritoneum to its left, and it was brought out of the wound with three inches above and four inches below it. Its mesentery was tied, and the growth was removed. Two Paul's tubes were tied into the bowel above and below, and the two pieces of bowel were approximated by sutures. A year later, as the artificial anus had not closed and the patient was quite well in his general health, another operation was carried out to restore the channel, and this has proved successful.

In a similar case a woman, aged 42, had a pelvic abscess complicating a growth of the pelvic colon. She was treated as in Case 2, and a year later her doctor wrote:—"The abdominal wound is all but closed and nothing passes there except fluid. All motion of a solid nature passes per anum." Unfortunately a local recurrence needed removal soon afterwards.

A. 3. ii. In some cases the patient's condition is too bad for the growth to be removed at the first operation. Then a Paul's tube may be tied in the delivered loop a little above the growth. Some days later, when the patient's condition admits of it, the growth is resected and the two ends united either at once or at a subsequent date.

CASE 3.

Carcinoma of the Sigmoid. Acute on Chronic Intestinal Obstruction. Colostomy with Delivery of the Growth. Resection five days later. Secondary Anastomosis. Pelvic Abscess. Recovery.

Mrs. P., aged 46, says that she has suffered for many years from constipation, and during the last few months this has been getting worse. She has not noticed any blood or slime. A fortnight ago she was seized with abdominal pain, and since then she has had no relief. The bowels have not been opened nor has she passed any flautus. She has taken opening medicine without avail, generally vomiting it. She has had one enema without effect. She has taken very little food and has had very little sleep. She has been in bed all the time except for two days at the early part of her illness. The pain and sickness are not quite so bad now as they were. She was last sick on January 1st in the afternoon, bringing up brown offensive material. She was sent to Guy's Hospital with her doctor's card. The abdomen was greatly distended, and three times while the patient was watched during half an hour, visible peristalsis could be seen about the position of the cæcum. The patient was then suffering from severe colic. She had shifting dulness in the flanks. The abdomen was neither tender nor rigid. The temperature was subnormal. Chronic intestinal obstruction, due to growth of the colon, was diagnosed, and it was thought probable that it was somewhere about the transverse colon. Rectal examination had revealed no growth in the pelvis.

Operation on January 1st, 1911.—The abdomen was opened by displacing outwards the lower part of the right rectus. The cæcum was at once seen to be distended, and the small intestines were also very distended. A large amount of clear fluid escaped from the abdomen. On passing the hand into the pelvis a growth was felt about seven or eight inches from the anus. It was a small contracting carcinoma. The bowel above it was greatly distended. It was seen that although it would be possible to make an anastomosis between the ileum and the bowel below the growth, it would not then be possible to perform a secondary resection of the growth. Moreover, the patient's condition was bad, although the pulse was only 80 before the beginning of the operation. Therefore a small muscular separation incision was made in the left flank, and a loop of bowel containing the growth was brought out through this wound and fixed in position by means of a Spencer-Wells forceps passed through the mesentery and clamped on a pad. The incision was then closed and covered with a sealed dressing. A roll of gauze was wrapped around the base of the loop of sigmoid, and then a Paul's tube was tied into the distended bowel one inch above the growth. The patient was infused about four pints during the night. She made very rapid improvement and regained her natural colour, her face becoming much fuller. She ate and slept well.

On January 7th, 1911, an attempt was made to remove the growth, which was projecting, with a cautery after painting it with cocaine 5 per cent. solution, but the patient complained of pain, and therefore a little A.C. was given. The projecting loop of bowel was then removed, the lower limb being divided first about two inches below the growth, then the mesentery, a wedge of which was removed, and lastly the bowel about three inches above the growth were divided. The vessels were tied and the two ends of the bowel were sewn together, starting at the mesenteric border and proceeding in each direction towards the free border, leaving an aperture just large enough to admit a small Paul's tube, which was tied in. The operation lasted an hour. The patient bore it well. Two days later the tube was removed.

About three months later, the colostomy not closing, an operation was done. The intestinal ends and an inflamed mesenteric mass was removed, and end to end union was made. The patient was well two years later.

B. When there is no hope of resection, colostomy is to be avoided whenever possible and short-circuiting adopted instead. In this way relief for some months to several years may be given.

I could give numerous instances of relief given for some months to several years. For instance, a man admitted into Guy's had a growth of the splenic flexure with extensive secondary growths in the peritoneum and glands, and a short-circuit between the transverse and pelvic colons enabled him to return to work for nine months. He died about a year after the short-circuit was made. Similarly with a growth of the ascending colon a short circuit between the ileum and the transverse colon affords relief. In a recent case with a growth in the pelvic colon about nine inches from the anus with secondary growths, I was able to make an anastomosis between the left iliac colon and the front wall of the rectum, and thus avoid a colostomy. It two other instances with secondary involvement and obstruction of the small intestine due to primary growth of the pelvic colon I was able to join the ileum to the front wall of the rectum and thus avoid an ileostomy. One of these patients lived for six months after the operation in comparative comfort.

These are sorry expedients, however, and the more one sees of cancer of the colon, the more one realises the great importance of early recognition and removal before severe obstruction develops.

Letters from Guy's Men on Active Service.

Rawal Pindi, B.G.H., B,
Amarah,
1, E, FD,
c/o India Office.

It seems a long time since I wrote and an age since I heard from you.

Getting the Guy's GAZETTE reminded me of you, and so here goes for a brief epistle.

For seven weeks now I have been away from my hospital at Amarah, have been up at the Front on Temporary Duty, and on Convoy duty up and down the Tigris with wounded and sick between the Front and Basrah; I have been with a British Field Ambulance up there, and with a Casualty Clearing Station, and so have seen what it is like in these places in the middle of a rush when a big battle is going on. I am at the moment on an ancient paddle boat proceeding up river again, and this time hope when we reach Amarah this afternoon to be taken off and return to the hospital; seven weeks of travelling up and down such a river as the Tigris, especially in such heat as we are now experiencing, is more than enough, and I am fed up to the teeth with it.

The last two days the thermometer has been 112° and 114° in the shade in the captain's cabin up in the bows of the ship, that is the coolest part by a long way, as he has a boarded roof and sides and two awnings, whereas aft we have only a scanty and ancient awning, and the heat from the engines is terrific. One sits about in a shirt and a pair of knickers and is constantly wet through with perspiration, and yet old hands out here say this is nothing to what it is going to be from June to November.

We have 200 Indians and 20 officers on board, a draft for the Front; last time I had 250 Indians and had a rotten time owing to the outbreak of a disease which must be nameless. (Censor)! I had three cases at intervals, on the way up, and had to drop one with direct contacts at Sheikh Saad, one at Orah, and one at the Front at our new camp at Felaiyeh.

The mosquitoes have been in great form this trip. At Basrah I was bitten all over my face, head, and both arms one night when it was too hot to even stick a mosquito net, but they are not Anopheles, though one runs across plenty of these at certain places up the river, Kurna and Ezras Tomb being about the two worst places for them.

The sand flies are a great trial, these are so small that they can get through the mesh of a mosquito net, so one is bitten by them every night whilst on this sort of gamut, and all day long too; they can scarcely be seen, but you feel them bite and get covered in small lumps afterwards.

In spite of all the pests and the heat I am at present keeping fit, but I can see one is mighty lucky if one does keep fit. I took down four R.A.M.C. Officers last time from the Front, and 17 other officers (including a Guy's Dental named Thomas), nearly all dysentery, malaria or paralytic. The Kut cases have all got down to Basrah and mostly already evacuated to India, they were all desperately thin, some of the Indians being almost skeletons. There is a lull here in the fighting, and we are all wondering what is going to happen.

How is Guy's going on? I presume you will be very short handed; the GAZETTE, however, seems to be kept up and very well too. I enclose a *Basrah Times*; its an awful rag.

I really can't write any more, my hands are too sticky, and it's difficult to hold a pencil. Oh for a breeze! and a fortune for a cold drink. Tigris water is all we can raise, and it is far thicker than Thames water.

Best wishes from
A. SEABROOKE.

Spinal Anæsthesia:

With reference to its use in the Trendelenburg Position and for the Prevention of Shock.

BY H. M. PAGE.

With a Note by HAROLD CHAPPLE, M.C.

FOR all ordinary uncomplicated cases inhalation anæsthesia as improved at the present day is still the method of choice. Ether, if not contra-indicated, after a preliminary injection of atropine with or without opium, is rightly preferred, given by means of Clover's apparatus, with the addition, if possible, of oxygen, or by the open method, when a warmed vapour should be blown to the patient if the administration is anything more than a short one, which warming can be very easily effected by coiling an extra long delivery tube in a small receptacle for hot water or by the use of a thermos flask, as in the apparatus designed by my colleague, Dr. F. E. Shipway. There are also special cases where ether is best given by the intratracheal method, by Crile's tubes, or the rectum. Warmed nitrous oxide and oxygen with or without the addition of some ether vapour may be the method to choose, if available. There is also the intravenous route, which may have advantages under certain circumstances, though there are few cases that, in my opinion, cannot be better managed with one or other of the above-mentioned methods of using ether in conjunction with subcutaneous or, if necessary, intravenous administration of saline or glucose solution. Chloroform is required for some cases, and in the form of A.C.E. or C.E. mixture is of great use for induction. When it is advisable to use chloroform all through the administration, I consider that the percentage method, with the addition of a small quantity of oxygen, is the best method to employ.

There remain, however, many cases in which those who are familiar with it will agree that great advantages can be obtained by the use of spinal anæsthesia. By this means either the whole or the greater part of the operative shock is done away with. (No form of general anæsthesia can prevent shock.) A more complete muscular relaxation is produced than by any other method of anæsthesia, thereby assisting the surgeon in his work, shortening the time of operative interference, and diminishing traumatism. The operations in which these advantages may be of special importance are those for acute abdominal conditions, especially if septic in nature; any prolonged abdominal procedure likely to be followed by shock; amputations; operations on the bones of the lower limbs, especially when the patient's vitality is lowered by exhaustion, sepsis, or hæmorrhage; and certain genito-urinary operations. At the present time there are many cases of injury to the bones of the lower limbs requiring plates, etc. Spinal anæsthesia is an immense help to the surgeon in all these cases owing to the complete muscular relaxation obtained, and in some will save life by preventing the very great shock often met with in difficult cases of fractured femur.

With regard to the risk of sepsis in spinal injection, a small amount of sterilised fluid sealed in a glass capsule is used, and the operation of injecting it within the theca after taking all ordinary aseptic precautions should be done without touching any part of the needle that comes in contact with the thecal membrane or the solution to be injected.

Though the position of spinal anæsthesia in surgery is now more or less generally accepted, and though there are many surgeons and gynæcologists who are familiar with the use of spinal injections with the Trendelenburg position, the fact that it can be used safely in this position is not generally recognised. Mr. Harold Chapple asked me to try spinal anæsthesia in connection with the Trendelenburg position, four years ago for certain selected pelvic operations. I have, therefore, ventured to report 70 cases in which the patient was put into the Trendelenburg position after intra-thecal injection. I could have reported many more cases in which the patient was put in a slight incline with the head lower than the body without any trouble occurring, but I have only included here those put into the Trendelenburg position. When this position is used it is better to combine a general anæsthetic with the spinal injection, for the small quantity of ether or chloroform mixture required to keep the patient unconscious when there is no reflex disturbance has no necrotic effect on the tissues and practically has very little effect on the after-condition of the patient. If nitrous oxide and oxygen be used there is no effect at all in this respect. The administration of nitrous oxide and oxygen for prolonged periods is quite easy after either a spinal injection or in conjunction with satisfactory local infiltration with novocaine, as recommended by Crile. In this way mental shock and distress are prevented and the patient escapes the discomfort of lying upside down for a long period. The general anæsthetic is only given to produce a state of unconsciousness, not surgical anæsthesia. However, 12 of these cases were operated on successfully without any general anæsthetic being given. Novocaine, the Saccharine Corporation's 5 per cent. solution with adrenalin was used in the majority of cases, the dose varying from $2\frac{1}{2}$ c.c. to 3 c.c., seldom under $2\frac{3}{4}$ c.c. The boy, aged 3, with ruptured liver, was given 1 c.c. of the novocaine solution. Stovaine, Billion's 10 per cent. solution, generally 6/10 c.c., never more, sometimes 5/10 c.c., was used in the others. About 2 c.c. of spinal fluid were drawn into the syringe containing the stovaine and reinjected. I vary the dose according to the size,

condition, and age of the patient, with some reference also to the size of the individual. Solutions to which glucose or other weight-giving substances have been added must not be used.

The injection is given with the patient lying on the side. Immediately after the injection the patient is turned on to the back and the thighs well flexed on the abdomen, this position is maintained for five minutes, after which the patient is got ready for the operation. The patient is put into the Trendelenburg position 15 minutes after the injection when novocaine has been used and 15 to 20 minutes after injection with stovaine, according to the rapidity with which the anæsthesia spreads upwards.

In the present series there was no case of surgical shock. In some cases there was a fall of blood pressure without quickening of pulse-rate, remedied immediately, if thought necessary, by raising the legs to a level with the rest of the inverted body; this loss of pressure which disappears when sensation and movement have returned to the legs, is, I believe, due to a mechanical vasomotor effect. Owing to the inverted position symptoms of general toxicity following absorption of the drug into the blood are practically absent.

Twelve cases were operated on without any general anæsthesia. The spinal anæsthesia in those cases, of course, was excellent. In the remaining 58 there was perfect anæsthesia and relaxation in 55. In several of these cases the operation was begun before any general anæsthetic was given; in none of them was the lid reflex abolished or the jaw relaxed by the small quantity of inhalation anæsthesia employed. In the three cases of partial failure a more or less deep inhalation anæsthesia was required. The surgeon experienced in the use of spinal anæsthesia is quite aware whether he is dealing with the complete flaccid relaxation due to intrathecal injection or the relaxation following a well administered general anæsthetic. There was no case of interference with respiration; no artificial respiration had to be done. No patient died on the table or before recovery from the paralysis. There have been no permanent sequelæ.

The Trendelenburg position was used after spinal injection in the following cases. "Recovered" in this list means that the patient recovered from the operation.

Cases in which the Trendelenburg Position was Used after Spinal Injection

	No. of cases.	Recovered.	Died.
Complete Wertheim's operation for carcinoma uteri	14	11	4
For carcinoma uteri	5	5	—
„ sarcoma uteri	1	1	—
„ fibroids	18	17	1
„ ectopic gestation	1	1	—
„ removal of tubes and appendix ...	4	4	—
„ „ „ tube and right ovary...	2	2	—
„ inoperable carcinoma uteri (tying arteries)	4	4	—
„ growths in the bladder	4	3	1
„ ventral hernia	2	2	—
For ovariotomy	3	3	—
„ ventral fixation	1	1	—
„ appendicectomy, curetting and fixing ovaries	1	1	—
„ large suppurating gland in mesentery	1	1	—
„ gastro-jejunostomy	1	—	1
„ carcinoma of sigmoid	2	2	—
„ intestinal obstruction	4	2	1
„ adhesions, intestinal	1	1	—
„ ruptured liver	1	—	1
Totals ...	70	61	9

Particulars of the Nine Fatal Cases.

1. Wertheim's operation. Patient died suddenly from pulmonary embolism three weeks after the operation.

2. Wertheim's operation. Patient died from hæmorrhage on the day following the operation. Much blood lost both on the table and afterwards. This was not one of Mr. Chapple's cases.

3. Wertheim's operation. Very anæmic, cachectic woman, with some œdema. She seemed to recover well from the operation at first, but died five days after.

4. Death after hysterectomy for fibroids. The patient was an enormously stout woman. The surgeon said that but for the relaxation produced by the spinal injection he could not have operated at all on account of her obesity. She recovered very well from the operation, but died from pulmonary embolism on the twenty-fifth day when practically well.

5. A young man who had been allowed to bleed from a non-malignant growth of the bladder until he was quite exsanguined, cold, and feeble to the last degree. The growth was removed suprapubically. He was not at all worse at the end of the operation. There was no hæmorrhage. He had lost too much blood to recover, and died on the third day.

6. The patient, who died after gastro-jejunostomy, recovered perfectly from the spinal injection and immediate operative interference, but died on the sixth day from acute intestinal obstruction, demonstrated by post-mortem examination.

7. The patient, who died after anastomosis for obstruction, was 18 years of age. She had been operated on eight days before for acute obstruction, a tube being put into the ileum. She died three weeks after the operation for anastomosis, the determining cause being toxicity due to the extremely septic condition of the abdominal wound, which was present before the operation done under spinal anæsthesia.

8. The other patient suffering from obstruction, who died, was a woman aged 68. She had a transposed heart. According to the report of the physician her heart was in a diseased and failing condition, apart from the acute disease, and she could not take a general anæsthetic. She had an attack of hemiplegia seven days after the operation and died a few weeks later.

9. The patient, operated on for ruptured liver, was a boy aged 3. He was suffering from intense shock with extreme dyspnœa. Several ribs were broken and the lungs were injured; there was double pneumothorax. He was not appreciably affected by the abdominal exploration, and recovered completely from the spinal paralysis, but died some hours after from the condition of his chest.

I consider that the spinal injections had nothing to do with the result in any of the nine fatal cases, that 2, 3, 5, and 7 had a better chance of life than if the operations had been done under general anæsthesia, and that Cases 4, 8, and 9 could only have been operated upon under spinal anæsthesia.

I should also like to report eight cases operated on under spinal anæsthesia in the Trendelenburg position at the West London Hospital by Dr. H. J. F. Simson. The anæsthetist was Dr. A. C. Sandston, of Christchurch, N.Z. The method used was the same as I have described. All the patients have recovered from their operation and there were no sequelæ and no trouble during the operations.

Note by Mr. HAROLD CHAPPLE.

During the last four years I have made use of spinal anæsthesia on many occasions in operations on the female pelvic organs, and am thoroughly in agreement with Mr. Sage as to its great value. As he has said, ordinarily the usual inhalation methods skilfully given are perfectly satisfactory, but when surgical shock is anticipated a spinal anæsthetic followed by sufficient ether to render the patient unconscious has proved of very great benefit. For instance, the so-called Wertheim's operation for carcinoma of the cervix, which was formerly rather dreaded because of the frequent association of great shock, can now safely be performed if this method of anæsthesia be employed, and especially if normal saline be at the same time introduced into the axillæ after the method of Arbuthnot Lane. The attitude with which one approaches this operation is now entirely different and it is not at all unusual to send the patient back to bed after a complete removal of the affected parts and a dissection of the pelvic glands with a full pulse running at about 92 or thereabouts. From the surgeon's point of view the other great advantage it affords is the complete relaxation of the abdominal muscles. This is particularly noticeable in stout women, who frequently take ether badly, and the greater ease with which the pelvic organs can be attacked is very satisfactory.

The method of introduction is simple, and if the patient be kept in a suitable position for a few minutes the extreme Trendelenburg position can be adopted with perfect safety. We have had no trouble with it, except that on a few occasions the patient has complained of severe headache for a few hours. There have been no permanent ill-effects of any kind. The momentary discomfort associated with the introduction is a small price to pay for the great advantages to be gained in the almost complete absence of shock and the facility afforded by the complete abdominal relaxation.

Pass List.

Royal College of Surgeons of England.

As a result of the recent Final Fellowship Examination, which was held from May the 11th to the 24th, the Diploma of Fellow was conferred on Francis Donaldson Saner, M.B. Cantab. The Diploma of Fellow was also conferred on George Sefton Miller, who had previously passed the requisite examination, and now attained the age of 25.

At the Final Examination for Licence in Dental Surgery, concluded on the 31st May, the following candidates were successful:—

PART I.

S. Sanders, W. R. Wotton, A. H. Bowes, W. A. Cooper, R. L. Cowley, L. D. Crabb, G. H. Danks, L. H. Dixon, T. A. M. Wilson, C. F. Hawkins, P. H. Marsh, W. Mercer, H. Wallis, D. E. Robinson.

PART II.

G. W. Allen, A. S. Blacklaws, C. M. Bullpitt, B. Eady, R. J. G. Halden, P. J. Hugo, C. H. Kidner, F. C. Lean, O. C. Lloyd, M. C. V. Thom, H. V. Vogt, H. M. Wermig, S. A. Woolf.

Society of Apothecaries of London.

At the Examination, recently held, the following candidates passed in the undermentioned subjects:—

SECTIONS I AND II.

Surgery.—H. Lamb, M. B. M. Tweed,
Medicine.—L. A. B. Moore.
Midwifery.—L. A. B. Moore,

The Diploma of the Society was granted to M. B, M. Tweed, entitling him to practise in Medicine, Surgery and Midwifery.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

The Crown Prince of Serbia has given his photograph for reproduction in a book which will shortly appear, written by Mr. and Mrs. Berry, Mr. W. Lyon Blease and other members of the party, entitled "The Story of a Red Cross Unit in Serbia," and has allowed the volume to be dedicated to him. The book, which is to be published by Messrs. J. & A. Churchill, deals with the recent History and Aims of the Serbs, as well as with the exciting travelling and other experiences of the Mission, the establishing of Hospitals, Sanitation, and the Treatment of a severe epidemic of Typhus. It tells of the Austrian Invasion, and how the Unit fell into the hands of the enemy. The volume is illustrated by photographs taken by various members of the party.

Founders of Hospitals.

THOMAS GUY.

[With acknowledgments to *The Hospital Gazette.*]

OF the very few hospitals in this country which are known by the names of their founders, Guy's Hospital is by far the most noteworthy. Thomas Guy was in every sense of the term the founder of that hospital, for not only did he provide the money for the building, but liberally endowed it to carry on its good work.

Thomas Guy was the son of Thomas Guy, lighterman and coal-dealer, and was born in 1644 (a year when the Civil War was at its greatest intensity (in Pritchard's Alley, Fair Street, Horselydown, Southwark. His father was probably a man of stern resolution, for he belonged to the religious sect known at that time as the Anabaptists, sometimes confused with the Mennonites who seceded from them. Although they had founded a church in London in James I.'s reign the Anabaptists seem to have emigrated largely to New England and Holland where they had established a church at Leyden. In 1640, after the persecutions of Laud had instilled a deeper fervour into the religious movement, many Nonconformists under the leadership of Hugh Peters returned from New England and became very active in securing converts and laying the foundation of those Puritan principles which proved so disastrous to the cause of Charles I. Since this time the Anabaptists have been known as Baptists, and it is doubtful whether they called themselves by the first name at all, for the term implies that they believed in re-baptism; whereas their doctrine was that, the christening of children not being baptism at all, it was necessary for the adult, when he had arrived at years of discretion and was in a position to understand its real significance, to undergo total immersion. The name, therefore, carrying in it as it did something of refutation of their arguments, was probably given to them by their opponents.

Guy the elder died young, when Thomas was but eight years old. His mother, who was a native of Tamworth, in Staffordshire, on the death of her husband returned to that town, where she gave her children a serviceable education; she married again in 1661.

In 1660 Thomas returned to London and was apprenticed to John Clarke the younger, a bookseller in Mercers' Hall Porch, Cheapside. His apprenticeship lasted eight years and qualified him by servitude for the freedom of the Stationers' Company which he obtained on October 7th, 1668. He was received into the livery of that Company on October 6th, 1673. Having served his apprenticeship Guy immediately set up in business for himself as a bookseller, printer and publisher in the corner house at the junction of Cornhill and Lombard Street, with a capital of about £200. The demand for books, especially of a religious and philosophical character, notably the Bible, was at this time very large. The period gives us a host of names of men who have left their mark on the literature of the country, *e.g.*, Milton, Locke, Bunyan, Butler, Dryden, Waller, Hobbes, Denham, Evelyn, Pepys, Burnet, Cowley, Defoe, and Swift. Tracts and sermons were also turned out with unfailing regularity. The English printing, however, was very bad and the paper of low quality.

In addition to this the printing of bibles was in the hands of a licensed few. This led many of the booksellers of London to import bibles from Holland where they were printed in admirable type on good paper, and in spite of the expense of importation the booksellers were able to sell at a much lower price than the authorised printers; the importation consequently was prohibited by law. Guy had followed the example set by the other booksellers, when the king's printers came forward and vigorously prosecuted the booksellers, with the result that they were so heavily fined and the bibles so frequently confiscated that the trade was brought almost to a standstill. At this juncture Guy and his partner Parker thought of a better plan, which was to secure the type from Holland, come to an arrangement with the king's printers, and print the bibles in England. They therefore contracted with the University of Oxford for their privilege of printing them, with the result that they did a profitable trade for many years, despite the fact that they were harassed by certain members of the Stationers' Company from time to time.

It is to be expected that in the natural course of a successful business such as printing Guy would make a certain amount of profit. It has been said that at this time he was a hard master and amassed wealth by employing "turnovers," or men who would work at lower rates than those usually paid; also that he lived very penuriously spending next to nothing on himself, that he would dine on his shop counter with an old newspaper as a tablecloth, and that his dress was invariably shabby. Another authority says that Guy bore a high character for probity, skill and zeal. Be this as it may, he was certainly in a financial position to invest in Government securities, and is reported to have bought largely, at a discount of from 30 to 50 per cent., the tickets given to the seamen of the Royal Navy in lieu of money; he is credited with having thus become possessed of stock in the National Debt to the amount of £45,500, which he converted into South Sea Company stock at par.

The South Sea Company was a project proposed by Harley and accepted by Parliament for reducing the National Debt. The idea was that the Company would amass great wealth by exploiting the mines of Potasi and Mexico and trading generally in the Southern Seas. But at the very formation of the Company the right to trade in the South Seas was monopolised by the King of Spain, who only granted the Company the

privilege of supplying the Spanish colonies of America with negroes for thirty years, and of sending one ship annually to Spanish America. Even out of the profits to be derived from this limited trade the King of Spain demanded one-fourth, together with 5 per cent. on the remainder. In 1718, after the decisive defeat of the Spanish fleet by Admiral Byng, all trade with Spanish America was immediately stopped, the Company's factories were destroyed and their effects confiscated. Notwithstanding this the Government still gave the scheme support, and a Bill was brought in by the Chancellor of the Exchequer giving the Company more extensive privileges in order to avoid competition. The Bill authorised the Company to take in the whole of the National Debt, redeemable and irredeemable, amounting at the time to 33 millions. Thus all who held Government securities converted the amount of their holding into South Sea Company stock. Immediately the Bill was passed the value of the stock, which even before had risen to £130 for £100 stock, mounted by leaps and bounds, and was quoted at £400. For the next two or three weeks it fluctuated and fell to £330. Then a rumour was spread that Stanhope had received an offer from the Court of Spain which would considerably extend the trade of the Company, and on the strength of this rumour a fresh issue of a million was made at the rate of £300 for £100 stock. The issue was doubly subscribed, the price of the stock rapidly advanced, and in a few days was quoted at £600. Again the directors made an issue at the rate of £400 per £100 stock. This was again over-subscribed and the directors made a further issue at £500. In a few days the stock rose to £550 and shortly after to £890.

At this price selling began, and the stock rapidly fell to £750. The directors in order to stop the selling then proposed to make advances of £4 per cent. to those proprietors who for want of ready money might be inclined to realise, and so successful was this expedient that public confidence was restored and the Company issued another subscription at the rate of £1,000 per £100 stock. These last subscriptions advanced to £2,000 per £100 stock, while the original stock rose to £1,000. At this point the bubble had reached its greatest dimensions and now began to show signs of bursting. The Bank of England at the instance of the Lords of the Treasury tried, for the sake of the public credit, to accommodate matters, but this was an impossible task. In June, 1720, the new stock had been quoted at £2,000 and the old stock at £1,000. In November it had fallen to £200, and by December 8th to £135. At this figure a rumour was circulated that the Bank of England and the East India Company had given their support, and this again conduced to more confidence, the stock rising to £210. Walpole then brought in a Bill which passed both Houses of Parliament, engrafting nine millions into the Bank of England, the same sum into the East India Company, leaving twenty millions in the hands of the South Sea Company.

The revelations which followed the bursting of the bubble showed that the whole scheme had been bolstered up by fraud. Lord Sunderland was forced to resign his office; Aislabie, Chancellor of the Exchequer, was expelled from the House of Commons and committed to the Tower; Craggs is supposed to have died by his own hands; while a large number of persons, including several members of Parliament, were punished with the utmost rigour.

Walpole throughout had strenuously opposed the scheme and exerted every effort to discountenance it, but he met with no success. He was referred to as the "Cassandra of politics," and as one who predicted impossible evils, but the bursting of the buble proved that he possessed the most valuable asset of the statesman—foresight (which when in opposition to popular impressions is frequently regarded as pessimism), and he immediately came into power.

Not only did the South Sea Bubble bring ruin to its own supporters, but it had encouraged unscrupulous company promoters to foist all manner of schemes upon a public who had reached a point of unreasoning credulity bordering on insanity. Thus, to mention only two, a company sent out its prospectus for erecting a grand dispensary with a capital of three millions, and another "for carrying on an undertaking of great advantage, *but nobody to know what it is.*"

Guy seemed to have seen quite early the real character of the South Sea Company and realised that it rested on no solid foundation, for he commenced to sell in a rapidly rising market at £300 and gradually but persistently disposed of his stock by the time it had reached £600. These transactions made Guy a rich man and he was able to devote large sums to philanthropic objects.

(To be continued.)

Births.

DICK.—On June 11th, at Tadworth, Surrey, the wife of Lieut. F. A. Dick, M.B., R.A.M.C. (T.), of a daughter.

KILLPACK—On June 17th, at Tanbridge, Haywards Heath, the wife (*née* Jimson) of C. D. Killpack, M.B., B.S., a son.

OROZCO-CASORLA.—On May 20th, 1916, at San José, Costa Rica, the wife of Raul Orozco-Casorla, L.D.S. Eng., of a daughter.

PAYNE.—On June 12th, at Lansdowne House, Alton, Hants, the wife of O. V. Payne, M.B., B.C., of a son (still-born).

Death.

PALMER.—On June 4th, suddenly, at Mundesley-on-Sea, Arthur E. Palmer, M.R.C.S., L.R.C.P., of Loughborough, Leicester.

F. A. K.

GUY'S HOSPITAL GAZETTE.

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Passim.

GUY'S men will be more than glad to hear that we can make a definite correction and apology for the insertion of the name of R. Montgomery in the list of Guy's casualties. The published name in the official list does not apply to Lieut. R. Montgomery, R.A.M.C., one time H.-S. to Mr. Steward.

WE deeply regret to hear that during the recent military activity two old Guy's men have been killed—namely, K. R. R. Trail, of the Medical School, and C. F. Snow, L.D.S.Eng., while the name of Lieut. W. S. Stranack has appeared in the list of wounded.

DURING the coming week we confidently expect to hear of many at Guy's who have satisfied one or other of the bodies examining for qualification, and the moment appears good to point out once again the parallel claims put forward by the Army and the Hospital.

We hold now, as always, that the immediate needs of the latter are equally deserving of attention as those of the military, and we hope that some will remember that there is a double purpose to be served in—for at least a few months—assisting to carry on the work of the house officers at Guy's. Firstly, these appointments *must* be filled, at any rate in part, so that new men coming on liberate those who have already occupied them, and, secondly, that in these days of increased difficulty of examination teaching there is some small debt owing to the Hospital School, which has assisted men to qualify.

We are not alone in these views, since the Military Medical Authorities have already shown themselves perfectly willing to grant at least three months before calling up the *enrolled* and newly qualified practitioner, when his request is that he be allowed to serve his hospital for that time.

WE would draw attention to the interesting article by the Matron upon the establishment of the College of Nursing, which goes so far towards the perfect organisation of the profession.

WE hear on good authority that an invitation has been extended to American surgeons to take up duties in British base hospitals; in fact, we believe that some few are already at work. Some time ago we heard rumours of this proceeding, and it would be interesting to hear from any whose experience can throw light upon the efficiency and advisability of the scheme.

As a result of consultation between the British Red Cross Society and the War Office, there has appeared a memorandum dealing with the correct usage of the Red Cross emblem. The paragraph dealing with its use by auxiliary hospitals, such as private houses

handed over to the military authorities, shows that they must have written authority from the War Office and must also fly the Union Jack alongside the Red Cross flag. Instructions are also issued for the use of the Red Cross on motor cars, stores and advertisement. It seems a point of little real importance, and yet we feel that a less general and unauthorised use of the emblem will be a great advantage.

RECENTLY there has been sent out from the Gazette Office to all Guy's men a double post-card, one half being stamped for return, and to be filled in with particulars as to military or naval service, etc., and a request that similar information should be supplied if the recipient knows of the doings or whereabouts of other Guy's men. The sending of cards is part of the scheme intended to result in a more or less complete list of Guy's men upon active war work, and we hope all will assist in the process even if their own post-card does not reach them. Mr. W. T. Curry, in the Gazette Office, will be pleased to receive any particulars.

WE publish a photograph of Lieut. William Reginald Pryn, who died on active service in No. 10 Casualty Station on Sunday, June 27th, 1915. We feel though, although so long in appearing, the picture will be more than welcome to his many friends among Guy's past and present.

Obituary.

2nd LIEUT. CHARLES F. SNOW, L.D.S., R.F.A.

Second Lieutenant Charles F. Snow, the elder son of Mr. W. H. Snow, Compton House, Peterborough, has been killed in action. Twenty-eight years of age, he was educated at the Cathedral School, Peterborough, and the Barton School, Wisbech. He entered Guy's Hospital Dental School, May, 1908, and qualified L.D.S. in May, 1910. He went to South Africa five years ago, and at the outbreak of war was attached, as senior lieutenant, to the Kimberley Regiment. Afterwards he was transferred as captain to the South African Medical Corps, going through the German West Africa campaign. Coming home in October, he was given a commission in the artillery.

The College of Nursing.

ONE of the most important events in the history of the Nursing Profession has happened in the second year of the Great European War, A.D. 1916: the establishment of the "College of Nursing."

For a quarter of a century efforts have been made to organise the nursing profession and to obtain for it legal status, thereby giving it the position which it undeniably has earned. Various Bills with this object have from time to time been brought before Parliament, even as lately as 1914, but, in spite of the magnificent work done by their promoters, it has not yet been possible to attain the organisation of the Profession by Act of Parliament; the failure being primarily due to the want of co-ordination and agreement between the different interests involved. The idea of a voluntary scheme of Registration embodied in an educational college was welcomed as a means of "putting the house in order," while the necessary work of promoting a Bill in Parliament proceeded at the same time. It was felt that when the Hon. Arthur Stanley, Chairman of the British Red Cross Society, offered to give the "scheme" house-room for the time being, his offices would be neutral ground where national work of an important character was already being carried out, and where members of the medical and nursing professions could meet in consultation without feeling themselves connected with any special "party." The consultations were successful, and on March 27th, 1916, the College of Nursing was registered as a company "limited by guarantee and not having a share capital." To establish a body which could set to work without delay or complications this line was taken, and the temporary title is "The College of Nursing, Limited." Since the date of registration many conferences have been held in various neutral centres, representatives of Nurse Training Schools all over the country have assembled in London and have had the opportunity of expressing their views, it is important that the Training Schools should know what is being done, as the college will deal largely with the course of instruction arranged for the probationer in training. As briefly set out on the leaflets now ready for circulation, the College has been founded with the following objects:—

1. To organise the Nursing profession.
2. To secure State registration for the trained nurse.
3. To make and maintain a Register of trained nurses, and by this means to protect the public.
4. To promote the interests of trained nurses.
5. To raise and maintain the standard of training.
6. To establish a uniform curriculum of training, and one partal examination.
7. To establish Lectureships, Scholarships, and in every way promote the advancement of the Nursing profession.

The College is managed by a Council of men and women, of not less than fifteen or more than thirty

persons, two-thirds of whom must be trained nurses. As yet there are no representatives from Ireland on the Council, nor of the private nurse working "on her own account," but there are still vacancies left. Branch councils for the management of local affairs are to be formed in large centres, Scotland has already held meetings to get the machinery for a branch council into working order, the advisability and importance of which must be apparent to everyone.

This *first* Council of the College has been nominated and co-opted, but in 1918 and every year afterwards, one-third of the Council retires by rotation, and vacancies are filled by the votes of the members, that is, by the trained nurses on the Register. *Every* member will have the opportunity of voting for the Council, as the necessary voting papers will be sent by post, and recording her vote will not be dependent on the member attending a meeting in London in person. *It is therefore important* that every trained nurse who takes an interest in the affairs of her profession should apply at once for registration by the College of Nursing (1) because a "Nurses Registration Bill" has been drafted, which provides that the register already formed by the College of Nursing shall be the first register *under the Act.* (The "first draft of this Bill has already been published in the nursing papers.) A nurse on the College register will, automatically, and *without further fee*, be placed upon the State register when the "Nurses Registration Bill" becomes law. Every nurse on the College register is *ipso facto*, and without further fee, a member of the College and is entitled to vote or the election of the Council. (2) Because the greater the number of trained nurses on the College egister the sooner will the Government grant facilities for the passing of the Bill, and the larger the number of members of the College, the greater will be its power to carry out the objects for which it has been founded. (3) Because the College of Nursing is a democratic body, governed by trained nurses, as two-thirds of the Council are trained nurses elected by members of the College, each one of whom being entitled to vote will, through her chosen representatives, assist in the government of the College, that is in the government of her profession. (4) Because it is proposed to build a College in a central part of London, which shall be the headquarters of the nursing profession, and to form centres in different parts of the kingdom. If a member is in any need of advice concerning her profession as a nurse, she will receive at these centres such help and advice as the authorities of the College are able to give. For the next three years known as "the period of grace," applicants for registration are required—

(*a*) To be at least twenty-one years of age.

(*b*) To be of good character.

(*c*) To hold a certificate or certificates of three years' training in a Nurse Training School or Schools recognised by the Council for the purpose of admitting practising nurses to the register of the College; or

(*d*) To hold a certificate of not less that two year training in a Nurse Training School recognised by the Council for the purpose of admitting practising nurses to the register, followed by at least two years' bona fide practice as a nurse; or

(*e*) To produce evidence of training to the satisfaction of the Council, having regard to the date at which the training was taken, followed by at least five years' bona fide practice as a nurse.

The fee for registration and membership has been fixed at £1 1s. (one pound and one shilling); there is no annual subscription.

It is quite clear that all expenses of building, maintaining an establishment and offices, keeping the register, arranging the machinery for examinations, etc., cannot be met by the one guinea fee required from each member (no college has ever yet been entirely maintained by the fees of its members), it is hoped therefore that the public may see in this College of Nursing a worthy object for endowment, and an opportunity for raising one of the finest memorials to the work done in the greatest war the world has ever known.

The present offices of the College are at No. 6, Vere Street, Cavendish Square, London, W., and all communications should be addressed to the Secretary, Miss Rundle, R.R.C., at that address.

L. V. HAUGHTON.

Change of Address.

Temp. Surgeon G. L. Attwater, R.N., from Royal Naval Hospital, Haslar, to H.M.S. *Chatham*, c/o G.P.O., London.

Surgeon E. J. Cooke, H.M.S. *Alsatian*, c/o G.P.O.

Cadet J. A. Bouic, 7886, D Co., Artists' Rifles, O.T.C., Hare Hall Camp, Romford, Essex.

Captain R. Stout, M.D., B.S., New Zealand Medical Corps, No. 1, New Zealand Field Ambulance, N.Z. Division, N.Z.E.F., France.

Captain T. D. M. Stout, F.R.C.S., New Zealand Medical Corps, No. 1, New Zealand Stationary Hospital, N.Z.E.F., France.

Lieut.-Colonel A. W. Sheen, T.D., R.A.M.C.(T.F.), from O.C. Welsh Hospital, Netley, to O.C. No. 34 (Welsh) General Hospital, I.E.F.

Lieut. V. Drew, 9th Reserve Battalion, Duke of Cornwall's Light Infantry, S.C.O.S.I., Candahar Barracks, Tidworth, Salisbury Plain.

Captain E. F. Clowes, R.A.M.C., from O, i/c, No. 5, War Hospital, Reading, to No. 50 Field Ambulance, British Expeditionary Force.

CORRECTION.—The address of M. Fred Hopson, Esq., given in our last issue, should read c/o The Senior *Naval* Officer, Zanzibar.

(The Editor will be very glad to receive a post card with notes of any change of address.)

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

DEAR SIR,—I have only just succeeded in getting some good photographs of my late son, W. R. Pryn, who died on June 27th last year. They are copied from a small snapshot taken at the front. I do not know if you are still reproducing photographs in the GAZETTE, and am sending a copy in case it might be useful. I have written some particulars on the back of the photograph, and much regret that I was unable to send it last autumn.—Believe me, yours sincerely,

Royal Naval Hospital, ISABEL PRYN.
Plymouth,
June 18th, 1916.

The Mercantile Medical Service.

DEAR SIR,—At the present time, when every trade and profession is looking anxiously ahead, it is essential for the welfare of the medical profession that it in its turn does not fail to guard, in so far as it can, the interests of its members. It is seldom realised by the majority of medical men that a most necessary, useful, and pleasant branch of the profession has its "dwelling upon the waters." I refer to the Mercantile Medical Service, which for many years has offered health-giving, instructing and entertaining work to medical men. Nevertheless, at the present moment it is the most unsatisfactory and neglected branch of the medical profession. The reasons for this are (i.) that medical men, regardless of the welfare of their sea-going brethren, take for their own pleasure or convenience nominal remunerations in permanent sea-going posts, and (ii.) that it is a branch of the profession in which the drunkard, the morphiomaniac, and the waster-in-general can usually find employment, the "dumping ground," in fact, for the "professional degenerate."

Thus, in the past the shipping companies have found it possible to provide medical men for their vessels without difficulty, and at a rate of pay inferior, as a rule, to that of their second mates! It is, then, incumbent upon us to secure an adequate remuneration for the ships' surgeons (i.) by refusing to accept a permanent appointment at sea for a remuneration less than that necessary to support one of the regular sea-going medical men, and (ii.) by insisting that those shipping companies, which continue to employ "medical degenerates" and "black legs" for the sake of economy, are prevented from securing the services of other medical men. It is to the younger men of the profession that we must look for the necessary assistance in bringing about a long-needed change in the conditions of the mercantile medical service, for it is in great part due to the past inconsideration and selfishness of the younger members that improvement has not already taken place.

In conclusion, may I suggest that the so-called "medical agents" be carefully avoided, and that 18 guineas per month be regarded for the present as a *minimum* wage for the medical man at sea?—I am,

Yours faithfully, L. J. RUTHERFORD,
St. Thomas's Hospital, M.B. Cantab.
London, S.W.
June, 1916.

An Appeal.

ROYAL MEDICAL BENEVOLENT FUND.

DEAR SIR,—The Royal Medical Benevolent Fund, the Great Benevolent Society of the Medical Profession, is sorely in want of money now.

Though in ordinary times the medical profession supports its own poor, in these war times this is no longer possible. At the May meeting the Committee had a balance of only £17 in hand and at the June meeting was faced with a deficit of £16. The demands were heavy and had to be met, and this could only be done by withdrawing £500 from the bank.

As the direct outcome of the war, not only are the ordinary cases of poverty greatly increased in number, but an entirely new class of case has arisen urgently requiring relief, in which without actual poverty there is great temporary distress; distress, however, which it is hoped will relieve itself soon after the war is over and the doctors serving return to their civil duties.

At the outbreak of war the medical profession responded freely to the nation's call. The Territorial medical officers were at once called out, and other medical men volunteered. Both alike had to leave their practice at very short notice, and often without being able to make adequate provision for its continuance and maintenance during their absence. Their pay went but little way to supply the loss which their absence entailed, for the working expenses of the practice could not be materially reduced. The result was that many families found themselves in very straitened circumstances. Rent, rates and insurance brook no delay, but worst of all, school bills could not be paid, and if help had not been quickly forthcoming, the children would have suffered for the patriotism of their father.

The following are typical of the cases with which our Fund has had to deal:—

A young doctor who had only been in practice a few years, volunteered for service, and was killed in action a few days later. He left a widow, aged 35, with two young boys, aged 3½ and one year, entirely without means. The Fund voted £25 for her immediate necessities, and put her into communication

with the Officers' Families' Association, which gave further help.

A practitioner, aged 38, earning £700 to £800, volunteered for service, leaving his practice in the hands of a neighbour, who was not a success, There were two young children, and another baby was born shortly after the husband left. The wife contracted pneumonia and nearly died. A resident patient had to leave the house. Rent and other expenses led to a debt of about £80. This the doctor could not meet, and he hurried back from the trenches to save his home from being sold up. The Fund voted £25, the Guild gave £15, the Officers' Families' Association £25, and the Professional Classes War Relief Council further help, with the result that he returned to the front with his immediate anxieties relieved.

A captain in the Territorials was called out and had to leave his practice in the hands of a *locum*, who proved a failure. There were seven children, aged 2 to 14. Financial difficulties arose and paymen of the school fees became impossible. Between the Fund and Guild and Officers' Families' Association the necessary fees were raised, and clothing, which was greatly required, provided.

These cases show well the way in which the Fund works, not only by giving relief itself in money and kind, but also by obtaining, through co-operation with other Benevolent Societies, more substantial assistance than it could afford alone.

But there is another class in which the distress is perhaps even greater and adequate relief more difficult. It is that of men who left home and a good practice in vigorous health, and who have come back, crippled by wounds or with health impaired, to a practice severely damaged by their absence, and without the strength or energy to regain the practice and position which they sacrificed.

Our Fund has set apart a special sum to meet emergency claims of this kind, yet the demands are so great that it will soon be exhausted. We cannot now rely on the profession alone to supplement it largely, for the medical profession, like all other professions, is hit very hard by the war, and has no longer its old resources to draw upon.

What is required is an Emergency Fund large enough to deal adequately with these emergency cases arising directly out of the war, and for this we are driven to appeal to the public as well as to our own profession.

We trust our appeal will meet with a liberal response both from the public and from the medical profession, for unless fresh funds are quickly forthcoming it will be impossible to continue the relief which is so urgently required.—We are, faithfully yours,

JOHN TWEEDY, President.
SAMUEL WEST, Hon. Treasurer.
G. NEWTON PITT, Hon. Secretary.

11, Chandos Street,
Cavendish Square, W.

Letters from Guy's Men on Active Service.

Mesopotamia, June.

I was very sorry to hear of poor Percy Beny's death. He was a good fellow, and if one has to die, well it is some satisfaction to one's people that one died doing one's duty. Ven is a hopeless chap, I don't write to him now because he never answers one's letters, but I am delighted to hear he is so fit. One day last week 95 R.A.M.C. and I.M.S. doctors turned up here, all tempy. lieuts. We have six of them attached to us at this hospital, and are jolly glad to have them as this heat is not conducive to work. We have been very lucky as they are a nice crowd, all six general practitioners from all over the country, two U.C.H. men, one Bart.'s, one King's, one Liverpool, and one Thomas's man, most of them men who have been qualified eight or ten years.

The heat has been too much for me recently and I have had two days off duty, 115° in the shade of our tent at 12 o'clock in the day is no joke; the wastage by sickness at present is appalling. We have now had over 100 cases of the Haffkin trouble in Amarah alone, mortality 39 per cent. The amount of dysentery one has to treat fair gives one the hump, as they are so terribly slow.

I am so pleased to hear news of Col. Graham; where is he? I hope he is fit. Yes, you told me Major Seabrooke had lost his leg; I hope his troubles are over now. We have killed two nasty snakes in our quarters this week, they fair strike terror into me; the scorpions are bad enough, but I draw the line at snakes. You can't magine how perfectly awful the flies are, they nearly drive one mad and they can bite like having a hypodermic shoved into you.

Davies-Colley is very fit, he likes the heat. G. D. Eccles is Embarcation Medical Officer, and is very busy. —Best of luck. A. SEABROOKE.

Sister Astley Cooper, Miss MacManus, wrote me that Sir Cooper's nephew was in Amarah, but I can't trace him.

Papers by Guy's Men.

Laurence C. Panting, M.D., B.Ch. Oxon., M.R.C.P. Lond., F.R.C.S. Eng.: Abdomino-Perineal resection of rectum by Coffey's modification of the two-stage operation.—*Lancet*, July 1st, 1916.

Hector Charles Cameron, M.D., F.R.C.P.: The reaction of the child to a faulty environment.—*The Practitioner*, July, 1916.

Russell J. Reynolds, M.B., B.S.: Methods employed in the X-ray Department in a military hospital with a few notes on one or two cases of interest, and on the treatment of trench-foot adopted there.—*Ibid.*

J. F. Rey, M.R.C.S.: An extreme case of "dropped" transverse colon in a young girl.—*Ibid.*

Major A. J. Hull, F.R.C.S.: The treatment of gunshot wounds by packing with salt sacs.—*The Dental Record*, July, 1916.

The Value of Starvation in the Treatment of Diabetes Mellitus.

CLINICAL LECTURE BY E. P. POULTON, M.D.

GENTLEMEN,—Before considering the new treatment of diabetes, just recently brought prominently forward as the result of Allen's researches at the Rockefeller Institute for Medical Research in America, it will be as well to consider as fully as the time will permit, the recent advances in our knowledge of the pathology of diabetes mellitus itself. It is only in this way that the full significance of the starvation treatment can be properly gauged.

Let me explain the elements of the situation. In a normal human being carbohydrate is absorbed from the intestine, and passes, chiefly in the form of dextrose, by the blood stream to the liver and muscles, where this dextrose is converted into glycogen, in which form it is stored for future use. Whenever the necessity for dextrose occurs at any particular part of the body, we must suppose there is an easy passage from these depots, by means of the blood stream, to the required spot, the carbohydrate always travelling in the blood stream as dextrose. This interchange of material takes place in such a way, that the percentage of dextrose in the blood always remains constant at about ·12 per cent. If this percentage increases we have hyperglycæmia, and this may lead to glycosuria in the endeavour of the kidneys to remove the excess of sugar from the blood.

In diabetes mellitus we usually have a hyperglycæmia, and this explains the glycosuria readily enough. But is the hyperglycæmia due to an over production of dextrose from the glycogen depots, especially the liver, or does the production of dextrose from the depots remain constant, and the sugar accumulate in the blood because it is not utilised in the body?

The last of these two possibilities is now considered correct, viz., that the primary failure in diabetes is due to the non-utilisation of dextrose by the tissues. The chief reason for this belief is that in normal animals an artificial hyperglycæmia leads to an increased oxidation of carbohydrates (as shown by the high respiratory quotient) whereas in diabetes, though the hyperglycæmia is great, the actual oxidation of carbohydrate is small. However, there is little doubt that in diabetes, though non-utilisation of dextrose is the chief factor, we also get an excessive production of sugar from the depots as a secondary process, and this tends to aggravate the hyperglycæmia.

What then is the cause of the non-utilisation of dextrose by the tissues? Let me put the theory first for the sake of simplicity, and consider the arguments in its favour later.

The pancreas produces an internal secretion which passes in the blood stream to the tissues and there acts as an amboceptor, linking a food molecule, such as dextrose, to the biogen molecule in the cell.

In diabetes there is a deficiency in this amboceptor, and so dextrose molecules cannot be anchored to the cell, and so they cannot be utilised. Here is a useful analogy suggested by Allen. You may look upon the amboceptor as mortar in building a house. Without mortar not only is there difficulty in building it, but the bricks already put together will tend to come tumbling down; not only will there be no utilisation of dextrose, but there will be a general disintegration of the tissues with an excessive invasion of the blood stream by dextrose molecules.

So much for the mechanism in diabetes mellitus. I should like at this point to emphasise the distinction between diabetes mellitus and glycosuria. The former is a disease, the latter is a symptom which has many causes. Diabetes mellitus is only one of these causes, but in man so important a cause that if you find sugar in the urine in a case, the odds will be much in favour of its being a case of diabetes. It is a great mistake to regard a mild alimentary glycosuria as of no importance. The majority of these cases are mild diabetes, and there is always the possibility that the case will progress into severe diabetes unless adequate treatment is adopted.

The suggestion that derangement of the pancreas has to do with diabetes is very old. It arose from clinical observation, that in certain cases of diabetes the pancreas was obviously pathological, atrophic, with concretions, etc. In fact as early as 1686 Brunner made an attempt to remove the pancreas in an animal to see the effect, but the experiment was unsuccessful. Eventually the doctrine seemed fairly established when two hundred years later von Mering and Minkowski succeeded in extirpating the pancreas and showed the occurrence of glycosuria. This is an operation of some difficulty. The best way of carrying it out is to perform two operations. Most of the gland is removed at the first one, and at the same time

the processus uncinatus is brought out and left intact under the skin. After complete recovery the small subcutaneous graft is easily removed in a second operation.

This important work which seemed to establish the doctrine without question, was followed by a period of disputes. A host of investigators repeated the operations, but failed to obtain diabetes, or at any rate only a transient glycosuria. It was pointed out that the reason they had failed was that the operation had not been completely performed; small segments of pancreatic tissue had been left behind.

On the clinical side the experiments at first met with the greatest enthusiasm, which later gave place to disappointment for several reasons. In the first place there was the lamentable failure to do any good to diabetes by treatment with pancreatic extracts; in the second place, in a very large number of autopsies on diabetes, no evidence of disease could be ascertained. It is the exception rather than the rule to find naked eye evidence of pancreatic disease in diabetes. Finally, so many differences were observed between the diabetes of a depancreatised dog and the diabetes of a human subject, that the general opinion seemed to be, that in diabetes mellitus the pancreas had really very little to do with the matter at all.

The chief reason of these differences lay in the essential nature of the operation of total extirpation of the pancreas. Animals in this condition differ from human diabetics in the fact that all their functioning pancreatic tissue has been removed. In diabetes mellitus, patients always have some functioning tissue remaining; there is only impairment of function in varying amount.

This line of reasoning led a number of investigators at about the same time to try to imitate diabetes mellitus exactly, by performing only a partial extirpation of the pancreas. The results have surpassed all expectation, and it may truly be said, that they have established the doctrine that pancreatic failure is the fundamental change in diabetes mellitus.

The work that has attracted most attention is that of Allen at the Rockefeller Institute, and this has so far led to the most practical results. This author has also published a book of some 1,200 pages, which is a most valuable reference to the immense diabetic literature.

Clinically diabetes mellitus has been divided into two categories:—

(1) Diabetes levis, in which glycosuria disappears on removal of all carbohydrate from the diet;

(2) Diabetes gravis, in which glycosuria persists even when the patient is kept on a rigid diabetic diet containing no carbohydrate.

The same two types of disease are found in dogs after partial pancreatectomy, the severity of the disease depending on the amount of pancreatic tissue left behind.

Diabetes levis is obtained if one-eighth or one-seventh of the organ is left behind. If one-sixth is left behind you may sometimes get it, but it is transient. In any case there is lowered sugar tolerance.

If one-tenth of the organ is left behind, diabetes gravis is invariably obtained; this may occur with larger fragments, but usually the diabetes gravis is transient, and gives place to a permanent condition of diabetes levis.

The problem as to whether any particular part of the pancreas is involved in normal carbohydrate metabolism has been attacked in various ways. Many experiments have been carried out in which approximately equal portions of different parts of the gland have been left behind at operation. The same grade of diabetes has always been produced. It also makes no difference if the portion left lies along the main duct, so that the external secretion still flows into the duodenum. This shows that the external secretion has nothing to do with the process.

Microscopical examination of the remnants of the gland left, after diabetes has been produced, have been made by various observers, with pretty concordant results. There seems to be general agreement that the acinar part of the gland which produces the external secretion remains unaltered, while profound changes—definite cell degeneration, loss of granules, etc.—are noted in the islands of Langerhans. (Some micro-photographs from a paper by Homans were shown.) However, it is still open to question whether these histological changes are associated with the cause of the diabetes, or are produced by the diabetic process itself. The latter view is supported by the following consideration: When only one-tenth of the gland is left behind at operation, severe diabetes follows in a few hours. It would be impossible for histological changes to occur in so short a time. They would require many days for their production, and as the animal is diabetic all the time, it would be reasonable to assume that the diabetic condition produced the cell changes, and that these would only be observed if the diabetes had not been arrested by treatment, but had rapidly progressed.

One of the main difficulties in considering that a deficiency of pancreatic internal secretion is the cause of human diabetes has been the lack of histological evidence of changes in the pancreas in many cases. This discrepancy is largely explained if we assume that, as in the experimental form, the deficiency is due to a lack of functioning tissue, and in this case we should expect to get changes similar to those observed in animals only in the very worst cases when the progress of the disease was most rapid, if we suppose these changes are only secondary to the diabetic process. No doubt further work will clear up this matter.

The resemblances between the forms of diabetes produced in this way and diabetes mellitus are very close. The onset is similar. After removal of nine-tenths of the gland, the disease starts acutely a few hours after the operation. When more of the gland is left behind the onset may be gradual, and there may be periods of intermittent glycosuria.

In severe forms acetonuria is present, and the breath has the typical sweet odour of diabetes

Date.	Diet.			Sugar.	Acidosis.					Wt.
	Carbohydrate	Cals.			Aceto-acetic Reaction.	Acetone.	Ammonia Nitrogen.		Alv. CO_2	
	gms.			gms.		gms.	gms.	index.	m.m.	lbs.
Nov. 11	90+	—	Bread 4 ozs.,	122	—	—	—	—	—	43
12	—	—	Milk 1 pint,	102	—	—	—	—	—	
13	—	—	Potatoes,	82	—	—	—	—	26·9	
14	—	—	Porridge *ad lib.*,	107	well marked	·4	·67	7·6	22·2	
15	0	80	Brandy 1 oz.,	56	less	·22	1·00	6·8	20·3	To stay
16	0	80	Water,	1·8+	more	·17	·45	16·9	29·7	in bed
17	0	80	Tea,	0	less	·13	·65	4·7	32·7	
18	3	92	Coffee,	0	more	·12	·08	—	—	
19	3	260	+Bovril	0	more	·12	·31	20	35·8	
20	4·5	456		0	well marked	·07	—	—	35	43
21	7·5	468		0	"	·11	·06	9	—	
22	10·5	586		0	"	·07	—	17	—	
23	24	752		0	"	·11	—	7·6	39	
24	18	728		0	"	·09	·05	15·4	—	
25	24	828		·71	—	·085	07	—	—	
26	18	728		—	—	—	—	—	—	
27	18	728		trace	+	—	—	—	—	
28	20	858		4·1	+	—	—	—	—	
29	26	892		2·2	+	·21	—	—	—	
30	26	892		10·6	less	·27	·27	5	—	
Dec. 1	24	872	Fluids,	22·3	"	·28	—	—	—	
2	0	67	½ oz. Cream	4·8	"	·23	—	—	—	
3	0	67		0	—	—	—	—	—	
4	9	294		0	—	0·7	—	—	—	
5	12	500		0	—	·10	—	—	—	37·5
6	15	700		0	little	·06	—		—	
7	18	712		0	Rothera	·06	—	—	—	
8	18	712		0	$FeCl_3$ only	·07	—	—	—	
9	18	762		1·75	" slight	·08	—	—	28·9	38·6
10	24	786		1·62	"	—	—	—	—	
11	18	712		3·0	"	—	—	—	—	
12	18	712		·56	"	—	—	—	—	37·5
13	18	712		1·14	—	—	—	—	—	
14	18	712		2·7	$FeCl_3$ slight	—	—	—	—	
15	0	67		0	"	—	—	—	—	
16	12	306		0	"	—	—	—	—	
17	15	700		slight	"	—	—	—	—	To get
18	18	712		0	"	—	—	—	—	up
19	18	762		0	"	—	—	—	—	
20	18	762		0	"	—	—	—	—	38
21	18	812		0	—	—	—	—	—	
22	18	812		0	—	—	—	—	—	
23	18	812		0	very slight	—	—	—	—	36·6
			Christmas.							

Lieutenant WILLIAM REGINALD PRYN, R.A.M.C.

Died in Belgium, June 27th, 1915.

mellitus. The urine, however, does not give the ferric chloride reaction for aceto-acetic acid.

The response of diabetic animals to diet is similar to that in diabetes mellitus, but this will be dealt with more fully later on.

Individual idiosyncracies have been observed in different animals after operations of the same severity. Some will live a long time though passing large amounts of sugar and showing great acidosis, others will rapidly waste and die.

Nervous or emotional glycosuria is well known in human diabetes. Allen has observed similar results in nervous dogs after partial pancreatic extirpation. In one small dog a trip to the operating theatre was sufficient to cause definite glycosuria. In another case, a partially depancreatised cat had an encounter with a dog and was injured. Severe diabetes began some time later in the cat.

Diabetic animals suffer from complications analogous to those met with in diabetes mellitus, inflammatory conditions of the eye, cystitis, and spreading ulceration, comparable to diabetic gangrene.

Perhaps the most important part of Allen's work began at this point. After showing the resemblance of experimental and human diabetes, he proceeded to investigate various factors which might increase or diminish the severity of the disease, and he then applied this treatment to human diabetes.

Diabetes gravis was first produced in dogs by the removal of nine-tenths of the pancreas. Two kinds of treatment were adopted: in one case the animals were starved until they were sugar-free; then protein and fat were gradually added with occasional bones, care being taken to keep them sugar-free all the time. The dogs remained very thin, but they were vigorous and lively. They had been kept alive for as long as six months at the time of publication, and showed no sign of succumbing to the disease. In the other case the animals were allowed to eat as much as they wished. Their condition at first greatly improved, but later they began to waste, in spite of the enormous meals, until they became as thin as the first set of dogs. After this point weakness and cachexia rapidly set in and death ensued.

In other experiments one-eighth to one-sixth of the pancreas was left behind and carbohydrate diet was given, which made the diabetic condition worse. At first the glycosuria could be stopped immediately by simple dieting. If the carbohydrate diet was given for longer the glycosuria could only be stopped by fasting, and finally the glycosuria could not be stopped at all, even by fasting.

It was found that if the glycosuria was stopped at once, the weight of the dogs remained high; if it was stopped later, the weight never became so high.

Let us first of all see how the amboceptor theory fits in with these experiments. In diabetes there is a deficiency of amboceptor, and so sugar is not utilised if given in excess. However, if the intake of sugar is temporarily abolished, the amboceptor will accumulate, and so later on small quantities of sugar can be utilised; in other words the sugar tolerance is increased.

In applying these results to human diabetes, it will be evident that some well known rules in the older method of treatment are all wrong; so much so, that the newer treatment seems to mark the beginning of a new era in fighting against the disease.

To begin with, these experiments bear out the general clinical experience, that it is beneficial to try and get rid of glycosuria by treatment if possible. Again they emphasise the fact, that the earlier the treatment the greater the chance of success. There is a tendency for diabetics who continue to pass sugar to become progressively worse.

The next point—and this runs quite contrary to the older teaching—is that it is beneficial to keep the patients thin. It is by this means that glycosuria will be arrested and some sugar tolerance regained.

Finally, acidosis is found to diminish, and this is quite contrary to what one would expect. I will just remind you that acidosis, consisting in the excretion of β-oxybutyric and aceto-acetic acid, and acetone in the urine, is produced from fat, whenever there is a want of carbohydrate, whether this want occurs owing to the absence of carbohydrate from the diet, or owing to the non-utilisation of it, as in diabetes. The whole subject was treated at length in two clinical lectures in the GAZETTE on September 25th and October 9th, 1915.

If a healthy man starves, acidosis occurs owing to the alteration of fat metabolism, because carbohydrates are suddenly removed. The same thing is noticed in the case of diabetes without acidosis.

In severe diabetes, with much acidosis, the effect of starvation is always eventually to diminish the acidosis, though in some cases there may be a temporary increase for the first day or two.

The reason for this apparently contradictory result is not quite clear, but there are probably two factors concerned. In the first place, starvation raises carbohydrate tolerance, and so enables the body to use to better effect any carbohydrate that is present; in the second place, starvation in diabetes produces marked diminunition in metabolism, and hence presumably the abnormal fat metabolism responsible for acidosis diminishes and so the acidosis diminishes.

I will now give you an example of a case of

Date.	Diet.			Sugar.	Acidosis.			
	Carbohydrate	Cals.			Aceto-Acetic Reaction.	Ammonia Nitrogen.		
	gms.			gms.		gms.	index	
Feb. 8	24	835		4	—	—	—	In bed
9	24	835		0	—	—	—	
10	24	1180		0	—	—	—	
11	24	1180		0	$FeCl_3$ slight	—	-	
12	24	1180		0	—	—	—	
13	31	1275		—	—	—	—	
14	31	1275		trace	—	—	—	
15	31	1275		0	—	—	—	
16	31	1275		·56	—	—	—	
17	31	1582		·16	$FeCl_3$ slight	—	—	
18	31	1682		0	—	—	—	
19	31	1682		—	—	—	—	
20	"	"		18·7	$FeCl_3$ more	—	—	
21	"	"		28	—	—	—	
22	"	"		22	—	—	—	
23	"	"		6·3	—	—	—	
24	"	"		27·5	—	—	—	To get
25	"	"		15·0	—	—	—	up
26	"	"		33·4	—	—	—	
27	"	"		38·3	—	—	—	
28	"	"		17·5	—	—	—	
29	"	"		—	—	—	—	
Mar. 1	"	"		30·9	$FeCl_3$ more	—	—	
11	31+	1682+	+ Porridge,	27·4	$FeCl_3$ marked	—	—	
12	"	"	Milk.	56	less	—	—	
13	"	"		73·3	more	1·5	16·7	
14	"	"		--	less	—	—	
15	"	"		29·2	marked	—	—	
16	"	"		67·5	—	—	—	
17	"	"		28·9	—	—	—	
18	91+	+ ?	4 ozs. Bread,	47·5	fair	—	—	
19	"	"	omit Porridge	30·5	fair	—	—	
20	"	"		29·2	Marked	—	—	
21	"	"		81·9	"	—	—	
22	106+	"		50·1	"	—	—	
23	"	"		99·2	"	—	—	
24	"	"		106·5	"	—	—	
25	"	"		75·6	"	—	—	
26	"	"		88	"	—	—	
27	"	"		83·2	"	—	—	
28	"	"		80·5	"	2·5	23·2	
29	"	"		81	"	—	--	
30	"	"		104·1	"	—	—	
31	Full diet, with extra Butter and			63·4	—	—	—	
April 1		"	[Vegetables	101·1	—	—	—	
2		"		160	very marked	—	—	
3		"		140·6	"	2·6	30·8	Air
4		"		87·6	—	—	—	hunger
5		"		111·2	—	—	—	Coma
6		"		66·3	—	1·0	28·7	
7		"		—	—	—	—	Death

* The ammonia index is the ratio of the ammonia nitrogen to the total nitrogen, expressed as a percentage.

diabetes which is one of those that Mr. Ryffel and myself have investigated, which will show you the value of this treatment. Various practical points in connection with the treatment will be considered in the next lecture.

M. T., a girl aged 8, was admitted to Esther ward, under the care of Dr. Fawcett, on February 13th, 1915. The onset of her diabetes was sudden, because three days earlier her aunt first noticed that she was very thirsty, and kept going to the tap for a drink of water. Her aunt then noticed that lately she had been getting thinner.

Her first stay in hospital lasted until June 25th. For the first month, on a fairly liberal diet containing 123 grms. carbohydrate, she passed amounts of sugar in the day varying from 42 to 170 grms., and there was slight acidosis. By treatment, according to a modified von Noorden's method, of alternating vegetable and potato days, the amount of sugar was diminished to a trace; it then rose at once. Finally it gradually grew less with restriction of carbohydrate, and she went out excreting less than 10 grms. of sugar in the day on a diet containing 87 grms. of carbohydrate; there was a slight aceto-acetic reaction in the urine.

On August 20th she was re-admitted on the verge of coma. This was successfully treated, and to prevent recurrence she was given a fairly liberal diet, as far as carbohydrate was concerned. She was passing about 100 grms. of sugar in the day, which is a large quantity considering that her body weight was only 43 lbs. The effect of treatment is shown in the diagram.

The new treatment was begun on November 15th. She was starved for three days, the only food allowed being 1 oz. of brandy, and on the fourth day she was given a small portion of greens.

On the third day she was sugar free. The diet was then gradually increased. But the total calorie value was always less than 1,000. The acidosis diminished as is shown by the diminishing quantity of acetone and ammonia excreted, and by the rise in the alveolar CO_2. Her weight at first remained at 43 lbs., but later it fell, and remained stationary at about 37 lbs. The treatment was continued until early in February, with somewhat of a break at Christmas. During all this time she was kept practically speaking free from sugar. On some days sugar appeared; starvation for one day usually caused it to disappear again. The excretion of sugar was on more than one occasion proved to be due to her walking round the ward and getting food from other patients. Thus the treatment seemed to be most successful when she was kept in bed. During the time this treatment was in progress, one had the feeling that it would have been possible to have kept her sugar-free indefinitely. If the treatment had been prolonged, and she could have been kept under strict supervision, to prevent her getting hold of carbohydrate, it is possible that she would have eventually gained greater tolerance for sugar, and she might have put on weight. As it was, it is difficult to see how she could have grown further with the small amount of food she was taking. She was certainly extremely thin, her facial bones showing through her skin. But she seemed fairly contented, and was fairly lively, and on occasions enjoyed walking in the Park.

Early in February the question of her going out of hospital was considered. On inquiry it was found absolutely impossible for her to continue this treatment at home. She was one of a large family, who were all taken care of by an aunt. It was impossible to keep her under proper supervision, and on previous occasions she had at home got hold of sweets and other carbohydrates. The only possibility seemed to be to get her back on to a more liberal diet, while she was in hospital, which she could continue at home.

This new treatment was begun about February 12th, with an increase of carbohydrate content and calorie value in the diet. The amount of food was very gradually increased; the sugar returned and acidosis increased. In spite of the more liberal diet the body weight hardly increased at all. Involuntarily, and owing to social causes beyond control, it is possible in the same case to compare directly the newer and the older methods of treatment.

The result only seems to emphasise the importance of the newer treatment, not only in abolishing sugar output, but also in diminishing acidosis, which is the cause of coma.

With a more liberal diet the sugar increased, and even though but little more carbohydrate was given to her, the acidosis showed a steady increase, until she ultimately died in diabetic coma.

(*To be continued.*)

Roll of Honour.

BEARD.—Killed in action in France on July 4th, Frederick Gerald Vesey Beard, eldest son of Frederick Beard, M.B., M.R.C.S., of the Crossways, S. Croydon.

Three Interesting Cases of Spinal Injury.

The following cases were under the care of Sir A. Lane in this Hospital:—

CASE 1.

Crushing violence applied to cervical spinal cord. Paralysis, quickly followed by death.

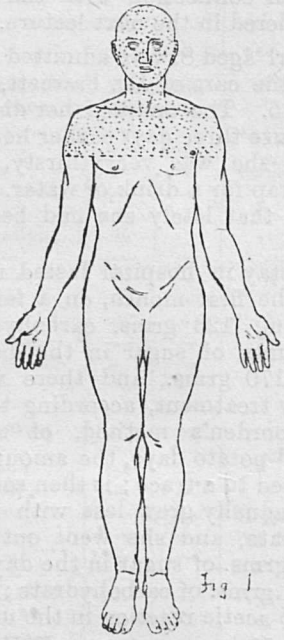
J. C., aged 13, was admitted to Cornelius Ward, under the care of Sir Arbuthnot Lane, on March 20th, 1916, at 6 p.m., suffering from severe injuries to the left side of the neck.

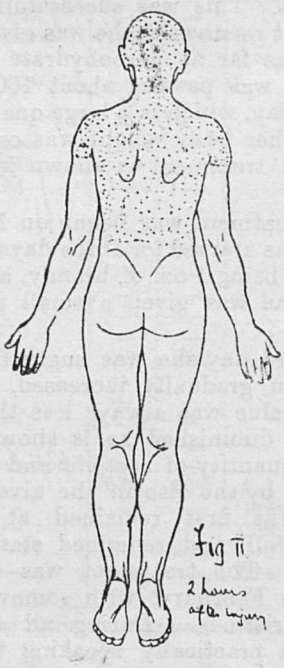
The history of the accident was as follows: Late in the afternoon the patient was pinned between the pole of a cart behind and the tail-board of a cart in front. The pole seemed to have struck the left side of his cervical vertebræ and the tail-board met the front of his chest just above the clavicles. Patient immediately fell down insensible, and remained so for a short time, and could not rise again on regaining consciousness. A doctor gave him a sleeping draught and recommended his removal to a hospital, and he reached Guy's between 5 and 6 p.m.

On admission patient was conscious, but dull, and on being asked his name replied in a feeble voice, and only when the question had been repeated several times. He had not been sick, and no blood had issued from nose or ears; palpebral fissure small; pupils reacted to light sluggishly; pulse 60; temperature 96·8°; respiration 20. Patient was placed lying flat on his back, and did not seem to be suffering any great pain; he was so dyspnœic that tracheotomy instruments were placed close by, ready, if necessary, for immediate use. Here, it might be added, that patient's mother said that he was rather accustomed to suffer from a "chesty cough" which always rendered his breathing difficult. There was some bruising and slight scratching on the left side of the neck and upper part of the thorax; arms and legs were quite flaccid, and patient was unable to move any of his limbs or to close his hands.

Cutaneous sensation, tested (a) by drawing a blunt pin lightly across the surface of the skin, and (b) by making firm impressions with the pin, was present only as far down as a line drawn transversely across the anterior surface of the thorax, at a level of half an inch above the nipples, and also over the anterior surface of the upper third of each arm. This lower limit area of sensation corresponded to the distribution of the supraclavicular nerves from the cervical plexus (Fig. I.). The shaded area represents the area of cutaneous sensation; anæsthetic area is unshaded.

Areas of sensation on the back seemed to vary. Two hours after the injury the firm impression of the pin could be felt over an area extending down to a line drawn across the body at a level of one inch above the highest points of the iliac crests (Fig. II.).

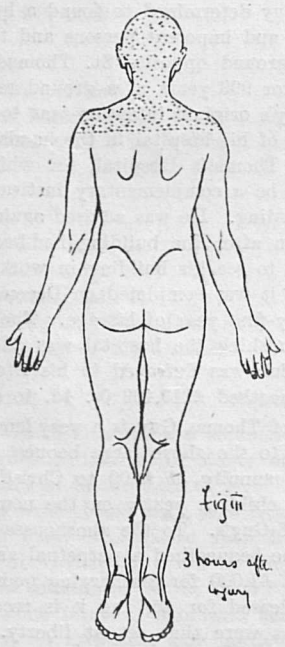




Further examination one hour later showed the whole of the back to be anæsthetic with the exception of an area extending upwards from the level of the third

dorsal vertebra (Fig. III.). The shaded areas represent areas of sensation; anæsthetic areas are unshaded.

Breathing was entirely diaphragmatic and consisted of a long inspiration followed after a pause of about one second by a long expiration. Two hours after admission the respiration had dropped from 20 to 15 per minute. Sphincteric control, both anal and vesical, was entirely lost, and both these sphincters were in a state of relaxation; in spite of the obvious paralysis a curious fact noticed was the state of continuous priapism. The reflexes were examined, and the knee-jerk, tendo-Achillis, and cremasteric reflexes were all absent; the plantar reflex was present. Two drops of 5 per cent. cocaine were placed in each eye, after which the eyes failed to react to the cocaine, thus suggesting injury to the sympathetic innervation of the eyeballs.



Patient was then turned over and placed lying with his face downwards, and palpation of his cervical vertebræ revealed a backward displacement of a vertebra, thought to be the sixth; a finger was then placed in the pharynx and seemed to reveal an unusual arching forwards of the cervical vertebræ. Head could be nodded and rolled from side to side, and only caused patient a little pain. Palpation of the abdomen revealed no abnormality. About six hours after admission patient vomited about 10 oz. of a greyish watery fluid which did not contain any blood.

Patient's condition showed no change until about 2 a.m., when he showed signs of marked cyanosis; this state continued until 4.40 a.m. during which time his rectal temperature was 96°.

At 5 a.m. patient was much worse, and the rectal temperature had risen to 103·2°; the breathing now stopped and the pulse had almost gone. Oxygen was administered and breathing was assisted by applying pressure over the anterior thoracic wall; as a result of these measures the breathing recommenced, but was slow and bad.

At 5.20 a.m. breathing again stopped and was restarted by the same measures as had just been employed; during this cessation of respiration the pulse was for a time indistinguishable, but, as the breathing restarted, it became perceptible again.

At 5.50 a.m. patient died. Breathing had been growing slower, deeper, and more difficult and seemed finally to fade away. During the last three hours the breathing, when present, was slow, deep, and increasingly laboured and accompanied by contractions of the alae nasi.

A post-mortem examination was held by Dr. French, who found fracture dislocation of cervical spine, fracture of sixth cervical vertebra; cervical spinal cord swollen and pulped opposite the sixth cervical vertebra. At 3.30 a.m. the pulse rate had increased to 92, after which it could not be estimated.

W. H. GRACE.

(To be continued.)

Pass List.

University of Cambridge.

M.B. DEGREE.

Third Examination (Part I).—Surgery and Midwifery.

At the Examination held recently, L. S. Gathergood was approved.

University of Durham.

FACULTY OF MEDICINE.

At the Convocation held on Tuesday, the 27th June, 1916, the degrees of Bachelor of Medicine (M.B.) and Bachelor of Surgery (B.S.) were conferred on Douglas Oliver Richards, M.R.C.S., L.R.C.P.

2ND EXAMINATION FOR THE M.B. DEGREE.

At the Examination recently held, Louis Lavine was successful in satisfying the Examiners.

Notices.

Treasurer's Gold Medal for Clinical Surgery, 1916.

As a result of the Examination held recently in Clinical Surgery, Mr. E. de Robillard has been awarded the Medal. Mr. L. S. Gathergood, *Proxime Accessit.*

Founders of Hospitals.

THOMAS GUY.

[With acknowledgments to *The Hospital Gazette.*]

(Continued from page 215.)

It would, however, be quite a mistake to imagine that Guy only exercised his charitable bent when he had acquired such a large fortune, which it must be remembered was within four years of his death. He had from quite an early age contributed large sums to charitable objects. Having a great affection for the town in which his mother was born, and in which he received his education, he had, in 1677, made a contribution towards the rebuilding of his old grammar school, and in 1678 erected an almshouse for poor women which he enlarged in 1693 to accommodate fourteen poor men and women. He likewise gave a sum of money towards the building of a spinning school for children, and made an annual subscription towards its upkeep.

Guy's interest in hospitals dated from 1704 when he became a Governor of St. Thomas's, although he did not attend the meetings of the court until 1707. Again his interest took a charitable turn and he erected and furnished three new wards at a cost of £1,000, and also contributed £100 a year for eleven years to the Samaritan Fund. In 1724 he made a further contribution to the hospital by erecting a new and imposing entrance.

In 1717 Guy gave £1,000 to the Stationers' Company for the benefit of poor members and widows of members, and further sums to be devoted to such charitable purposes as he might from time to time decide.

Guy had no ambition for civic honours, otherwise he might have figured as Lord Mayor. He had been admitted to the freedom of the City of London in 1673, and several years later was elected a sheriff, but, refusing to serve, was mulcted in the sum of £400 as a fine.

In 1690 Guy unsuccessfully contested the parliamentary seat of Tamworth, which returned two members, and alleged corruption against one of the successful candidates; the petition, however, which he brought was dismissed. In 1695 he was returned with Sir Henry Gough and sat in the parliament which lasted until 1698, when, at the general election, he was again returned at the head of the poll with John Chetwynd, who, however, was unseated, giving place to Sir Henry Gough; this Parliament lasted until December 19th. 1700. Again Guy was returned at the head of the poll with Sir Henry Gough, the Parliament being dissolved after nine months. Guy held the seat at the ensuing election, his co-representative being the Hon. Henry Thynne. This Parliament lasted only six months, when Guy was again returned with the Recorder of Tamworth, the Parliament lasting until 1705. Once again Guy was successful at the poll, and he was thus a member of parliament continuously from November, 1695, until April 15th, 1708. During this time he had presented Tamworth with a new Town Hall. He again stood at the general election of 1708, but lost the seat. Being somewhat indignant at his rejection he refused to contest the seat again and threatened to pull down the Town Hall and almshouses, but the philanthropic nature of the man asserted itself and by his will he endowed the almshouses with a perpetual annuity of £125, but made the stipulation that the recipients of the charity must be inhabitants of certain neighbouring parishes and not of Tamworth. He did, however, leave a small legacy to the Vicar of Tamworth and a like sum to one of its Nonconformist ministers.

In 1720 Guy determined to found a hospital for the cure of sick and impotent persons and took a lease of a piece of ground opposite St. Thomas's Hospital in Southwark for 999 years at a ground rent of £30 per annum. Guy's original intention was to place the administration of his hospital in the hands of the governors of St. Thomas's Hospital, for which, indeed, he meant it to be a complementary institution to relieve the overcrowding. He was advised against this action, however, soon after the building had been begun. Guy did not live to see his building in working order, but died just as it was completed on December 27th, 1724, in the eighty-first year of his age. The cost of building and furnishing the hospital was £18,793 16s. 1d., most of which was defrayed in his lifetime. By his will he bequeathed £219,499 0s. 4d. to endow it.

The will of Thomas Guy is a very lengthy document. In addition to the above large bequest he bequeathed a perpetual annuity of £400 to Christ's Hospital for taking four children yearly on the nomination of the governors of Guy's. To the almshouses and library at Tamworth he bequeathed a perpetual annuity of £125. He also left £1,000 for discharging poor prisoners who could be released for £5, and it is recorded that 600 poor persons were thus set at liberty. To his poor aged relations he gave annuities amounting to £870, and to his younger relatives and executors £75,589. At his death the sum of 1,000 guineas was found in his iron chest, and this was utilised by his executors in giving him an elaborate funeral after lying in state in the chapel of Mercers' Hall.

By an Act of Parliament (11 Geo. I., cap. 12) the incorporation of the charity was obtained in accordance with Guy's will, with power to the governors to finish and furnish the structure for the reception of upwards of 400 sick and diseased poor people, besides twenty lunatics to be provided for in a separate hospital.

Maitland says: The Corporation was no sooner established by Parliament than the President and Governors set heartily about the work, choosing their

officers and servants and taking in patients, whose number at first was 402. And for the more effectual preventing the inferior servants of the hospital from preying upon poor patients or their friends, have granted them such considerable salaries, that they can handsomely subsist upon their wages without imposing upon any person as will appear from the following account:—

A List of the Officers and servants belonging to Guy's Hospital with an account of their respective Salaries and Wages.

	Per annum.		
Treasurer	0	0	0
Clerk	40	0	0
Steward	80	0	0
Chaplain	80	0	0
Two Physicians, £40 each	80	0	0
Two Surgeons, £40 each	80	0	0
Apothecary	80	0	0
Surgery man	30	0	0
Apothecary's two servants	78	0	0
Butler with his horse	67	2	8
Cook and her servant	32	0	0
Porter	35	0	0
Beadle	30	0	0
Matron...	50	0	0
Eleven Sisters, £25 each	275	0	0
Eight Nurses, £16 each	128	0	0
Twelve Watchwomen, £10 8s. each ...	124	16	0
One brother belonging to the Lunatics ...	35	0	0
One Sister belonging to the Lunatics ...	25	0	0
Sum total	£1,349	18	8

After Guy's death, Dunton, the eccentric bookseller, wrote a pamphlet entitled "An Essay on Death-bed Charity exemplify'ed in the Life of Mr. Thomas Guy," As Dunton also wrote books with such titles as "Dunton's Whipping Post, or a Satire upon Everybody"; "The Danger of Living in a known Sin . . . fairly argued from the remorse of W. D. of D."; "The Life and Errors of John Dunton," etc., and had also quarrelled with Guy, his criticisms can hardly be regarded seriously even if there were any justification for them, which there is not.

Guy lived in very stirring times. During his lifetime six monarchs had occupied the throne and the country had been under two Lord Protectors. During his apprenticeship he had witnessed the ravages of the plague, which, starting in Drury Lane with only two cases, soon swept all over London. The country had been ravaged by civil war followed at intervals by wars with Holland, Spain and France. There is nothing to show that the state of the country affected Guy in any way even when the plague was at its height. Defoe says: "We had no such thing as printed newspapers in those days, to spread rumours and reports of things; and to improve them by the invention of men, as I have lived to see practised since." No doubt the absence of papers made it easier for people to preserve their equanimity.

In the court at the entrance of Guy's Hospital is an elaborate brass statue of Guy, in the livery gown of the Stationers' Company, which was erected on February 11th, 1734. Pennant, describing this statue, says. "He is represented standing, in his livery gown, with one hand raising a miserable sick object, and with the other pointing to a second object on a bier, carried by two persons into his hospital. This superfluity cost a thousand pounds."

In 1728 the admissions to Guy's Hospital were 1,544. In 1734 they were 1,755. It is interesting to note that the figures for the same years at St. Bartholomew's were 4,511 and 5,194, and at St. Thomas's 5,274 and 5,061.

A. H. COUGHTREY.

Appointments.

R.N.A.C.

The following appointments have been notified:—

Temporary Surgeon Attwater to H.M.S. *Chatham.*

Temporary Surgeon E. J. Cooke to H.M.S. *Alsatian.*

R.A.M.C.

Temporary Major E. H. Starling to be temporary Lieut.-Colonel.

Temporary Lieutenants to be temporary Captains:—J. F. Wheeler, H. E. H. Tracey, L. W. Evans, R. D. Bridger, T. G. Stevens, W. Robinson, J. Young, A. Wylie, P. W. Moore, E. F. Clowes, W. J. D. Smyth, R. H. Ashwin, S. Hodgson, A. M. Roome.

To be temporary Lieutenants:—C. E. Bartlett, H. Tipping, L. Bensted.

The following temporary Lieutenants have relinquished their Commissions:—J. E. Hodson, R. D. Mothersole, D. Allan.

Territorial Force, R.A.M.C.

London Field Ambulance:—Major (temporary Lieut.-Colonel) J. A. Masters relinquishes his temporary rank on alteration in posting. Captain L. Milton from General Hospitals to be Captain.

Welsh Field Ambulance:—Lieut R. Willan to be Captain.

Mentioned in Despatches.

The name of Captain (temporary Major) T. F. Brown should be added to those given in our last number as having been mentioned in despatches relative to the operations in Egypt.

Major R. T. Brown is mentioned in a despatch received rom Lieut.-General Smuts, Commander-in-Chief of the East African Force, dated June 30th, 1916.

Honours.

D.S.O.—Major R. T. Brown, R.A.M.C., has been awarded the Distinguished Service Order for gallant services rendered in the field.

Civil.

N. S. Carruthers, M.R.C.S., L.R.C.P., has been appointed District Medical Officer of the Blofield Union.

R. Hedden, M.R.C.S., L.R.C.P., has been appointed Certifying Surgeon for the Honiton District, Co. Devon.

J. J. Murray, M.B., B.Ch., has been appointed Dispensary Medical Officer, Downpatrick.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Medical Who's Who, 1915. (London, The Fulton-Manders Publishing Company.) 10/6 net.

This extremely useful volume has been made even more complete than in former issues, and shows an increase of 200 pages. An obituary list is inserted giving the names of those who have passed away in 1915 and the first two months of the present year, and the names of those who have died in service are indicated. The index of towns with the residing practitioners is particularly useful. Medical and Nursing Journals are classified at the end of the book.

The Editor expresses hope of an enlarged volume and greater circulation in future, both of which should readily be obtained.

Radium, X-rays and the Living Cell. By Hector A. Colwell, M.B., and Sidney Russ, D.Sc. (Published by G. Bell & Sons, Ltd., London.)

This book is well produced and the plates are excellent. The object claimed is the description of main experimental facts as to the effects of the X-rays and the rays of Radium upon living cells. Part I. is devoted to an extremely interesting survey of the general properties of the emanations, and should provide general information as well as form a basis for experimental investigation. Part II. is given to systematic description of effects on living tissues. The subject is not approached from the clinical aspect, but examples have been taken from clinical observations. A large proportion of the observations are connected with the action of the rays on malignant cells, and some of the deepest investigations have been made in this direction.

The book will serve excellently to aid those interested in the subject in the further pursuit of a very promising form of therapy.

The Diseases of Women. A Hand-book for Students and Practitioners, by Sir John Bland-Sutton and Arthur E. Giles. 7th Edition. 170 Illustrations. (London: William Heineman.)

In the present edition of this excellent work a thorough revision has been made. The most important re-arrangement is in Part II., where, in accordance with modern views, the anatomical system of classification of disease is dropped in favour of the pathological method. The change is for the better in certain directions, but is liable to create some confusion in others. A topographical summary is given in Chapter xlvii., which readily provides the connecting link with the older system.

The illustrations and plates have been revised and improved, the whole forming a most valuable little volume.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Marriages.

HANCE—LEONARD.—On June 24th, at St. Peter's, Wolvercote, Oxon., Captain J. Bennett Hance, B.A., M.B., B.Ch. Cantab., Indian Medical Service, to Catherine Henriette Lawson, only child of the late Charles Lester Leonard, M.A., M.D., of Philadelphia, U.S.A., and of Mrs. Leonard, Woodstock Road, Oxford.

ATTWATER-LOWE.—On June 20th, at St. Peter's, Streatham, S.W., Geoffrey Lewis Attwater, M.A., Cantab., M.R.C.S., L.R.C.P., Temp. Surgeon, R.N., to May Francis Lowe, daughter of the late Robert Lowe and Mrs. Lowe, of West Norwood, London.

HEASMAN-WOOD.—On June 3rd, in London, Herbert Wilks Heasman, M.R.C.S., L.R.C.P., son of late Arthur Heasman, of Rowfant, Sussex, to Agnes Chichele, widow of Arthur Wood, I.C.S., daughter of late Major-General George Chichele-Plowden and Mrs. Norton Wood, of Hurlingham Court, S.W.

WHITWORTH—GREENHALGH.—On June 21st, at Church Kirk, Lancashire, William Cuthbert Whitworth, M.R.C.S., L.R.C.P., of St. Agnes, Cornwall, to Hannah, daughter of the late Mr. Frank Greenhalgh, of Church.

Death.

TICEHURST.—On July 7th, at Huntbourne, Tenterden, Kent, Augustus Rowland Ticehurst, M.R.C.S., L.S.A., late of St. Leonards-on-Sea, aged 70.

F. A. K.

GUY'S HOSPITAL GAZETTE.

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Passim.

AT a General Court of Governors, held on Friday, July 7th, 1916, Major the Hon. R. V. Grosvenor was unanimously elected as a Governor to the Corporation and appointed an additional Member of the House-Committee.

IT is gratifying to be able to report that an anonymous donation of £2,000 was received at the Hospital recently, and a further anonymous gift of £1,000 in the form of 4½ per cent. War Loan Stock has been promised for the endowment of two Cots. We trust these splendid donations may be followed by other such gifts which will be especially appreciated during this present crisis, when the expenses of the Hospital are such an additional burden on the finances of the Institution.

WE are pleased to report that at recent Meetings of the General Court Sir Arbuthnot Lane, Bt., M.S., and Sir E. Cooper Perry, M.D., were appointed Consulting Surgeon and Consulting Physician to the Hospital respectively, on retirement under the age limit; and in consequence of the vacancies thus created on the Staff, Mr. C. H. Fagge, M.S., and Mr. L. Bromley, M.C., have been appointed a Full Surgeon and an Assistant Surgeon to the Hospital respectively. In view, however, of the exceptional conditions brought about by the War, all these Members of the Staff have kindly acceded to the unanimous wish of the Governors and of their Colleagues to continue their present duties for one year from May 1st, 1916, or for the duration of the War, whichever may be the earlier date.

THE Astley Cooper Prize, 1916, for a Treatise upon "The Physiology and Pathology of the Pituitary Body," has been awarded by the Physicians and Surgeons of Guy's Hospital, as Trustees, to Dr. W. Blair Bell, of Liverpool.

A WAR SAVINGS SOCIETY has been started for every one connected with Guy's. Sir Cooper Perry will act as chairman, Mr. W. J.

Curry as treasurer, and Miss Huggett as secretary. The committee consists of the Matron, Miss Grundy, Messrs. Croucher, Saltmarsh and Beale. It is desired to reach all connected with the Hospital in any sphere whatever, and information can be obtained from any of the officers or committee of the Association.

WE would call attention to a small but apparently reasonable request for the night nurses. On occasions, the sounds arising within the swimming bath building have been so boisterous that their afternoon's sleep has been seriously spoiled. We feel sure that their complaint will be considered.

AT the end of the present month more Residents will be leaving us, and among them Messrs. Curle and Richards have already taken up their commissions in the R.A.M.C. We welcome the new-comers who will take their places, and express appreciation of the vigor and rapidity with which many of these latter have qualified in order to carry on the work of the House appointments until their turn for relief shall arrive.

THE number of our men who have entered the Navy as Surgeon Probationers is increasing weekly, and would show us a good round figure. We seldom make mention of their continued departure, but in passing feel constrained to give them a wish of good luck.

As we go to press we hear of the marriage of Mr. B. Burnside, M.R.C.S., L.R.C.P., to Miss Grace Gould of Bath. We offer them our heartiest congratulations and good wishes.

IT may interest some of the newly qualified or retiring men that to all appearances the list of temporary naval surgeons is again open. At least the letters sent out by the Admiralty in answer to certain previous inquiries would seem to suggest as much.

IN our present issue we publish an obituary notice of that most popular old Guy's man, Captain A. Seabrooke. In our next we hope to reproduce a portrait, which at present we have been unable to obtain.

ON Saturday, July 29th, at 7 p.m., will be held the Residents' "Going-Off" Dinner. We hope for a good and cheerful gathering to express our appreciation of the work of those who are about to leave us.

WE understand that the Wills Library is shortly to close during the usual summer recess, and are asked to call students' attention to the necessity of returning books taken away from the library on loan.

A SMALL extract from Sir Douglas Haig's despatch appears to us well worth recording and remembering :—

THE MEDICAL SERVICES.

"All branches of the medical services deserve the highest commendation for the successful work done by them, both at the front and on the lines of communication. The sick rate has been consistantly low; there has been no serious epidemic, and enteric fever, the bane of armies in the past, has almost completely disappeared owing to preventive measures energetically carried out."

Obituary.

ALEXANDER STANGER SEABROOKE, B.A., M.B., B.C.Cantab., L.R.C.P.Lond., M.R.C.S.Eng.

Captain, Royal Army Medical Corps.

CAPTAIN A. S. Seabrooke, who died on July 1st in Mesopotamia, at the age of 31, was the second son of Mr. and Mrs. Jonathan Seabrooke, of Grays, Essex. He was born on October 26th, 1884, at Marsh House, Grays, and, when nine years old, went to Maze Hill School, St. Leonards.

A school friend at St. Leonards and Tonbridge writes:—"I am most awfully sorry for you all, and can dimly realise what his loss must cost. Such a good fellow in every sense of the word as he was, too! It takes me back many years when he arrived as a small boy at Maze Hill. From that moment he was popular with all. And so it was in after life at Tonbridge, at Cambridge, and then at the hospital. Words are small comfort at these times, I know, but it should help you to think he died spending himself for others, a splendid example for us who are left behind."

In 1898 he went to Tonbridge School, where he became head of his house. A master writes:—"I remember his coming here so well. He was such a dear little chap then, and such a fine fellow before he left. The war has been very cruel to us here at Tonbridge lately. We have lost some of the very best, and Alec was among those. It is awful for the mothers, and, as one of them wrote, 'It tears my heart to let my boy go, but it would break it if he had not wanted to go.' . . We need not grieve for him, but the loss is yours and ours."

His house-master says:—"And so one of the very best boys that ever came to Tonbridge School, and one, I know, of the very best sons that ever lived, has gone. And all that his friends at Tonbridge can do is to send you their deepest and must heartfelt sympathy. It is no exaggeration to say that of all the 300 boys who were under our care at Judde House, not one had a warmer place in my heart than your dear Alec. The most unselfish of men has gone, and not only you who loved him, but his country, is the poorer. Tonbridge School pays honour to his memory!"

Alec Seabrooke was a keen sportsman. His father taught him to use a gun when he was only ten years old, and he became a very good shot. There could be no more congenial companion for a walk with a gun. He was an untiring sportsman after partridges in September, and, owing to his walking powers, was generally found as outside gun, right or left. He was no cricketer, nor did he achieve success as an oarsman, but Guy's men can tell you of his prowess at football. He played golf, and on one occasion won a cup at the Gray's Golf Club. He was a powerful swimmer, and was quite at home on horseback.

In 1903 Alec Seabrooke proceeded to Christ's College, Cambridge, where he entered heartily into the life and spirit of the University, and was a member of the Mounted Infantry Corps.

The Master of Christ's says:—"May I send you, on behalf of the College, and especially of myself, our deepest sympathy at the loss of your dear son? He was one of the very best, most popular up here, a splendid influence in the College, and a real friend of mine. I always try to keep in touch with 'my boys,' and only last week wrote to him, a letter, alas! he'll never see."

Entering Guy's Hospital in 1908, Alec Seabrooke had an unusually successful career, not merely from academic brilliance, but because he was recognised as a man of exceptional character, who gained the confidence of every one with whom he came in contact. He was President of the Guy's Residents, and held House Appointments for two years, including House-Surgeon and Resident Obstetric Physician. In March, 1915, he gave up the post of Resident Obstetric and joined the Royal Army Medical Corps. After a short period of training at Aldershot he proceeded to France, where he was attached to the Rawal Pindi Hospital.

The following letters, many more of which remain unpublished, bear eloquent testimony of his great work there:—

"The news of the death of your distinguished and gallant son, Captain Alec Seabrooke, has filled our hearts with grief and the deepest regret. Though unknown to you, my wife and I long to offer you our truest sympathy in your sorrow. Last October we were summoned from Scotland to Wimereux to the bedside of our son, dangerously wounded at the battle of Loos. He was not expected to live, and for three weeks was on the 'dangerous list.' Nothing but the most devoted and clever watchfulness of that dear son of yours carried him through. The most brilliant specialists were watching the case, a deep head wound, but it was the clever watchfulness from hour to hour, and, at first, from moment to moment, that saved the boy's life. My boy writes in great sorrow at the loss of his friend. 'Without the slightest doubt I owe him my life,' he says in his letter. Both our boys were in the Cameron Highlanders. The elder was killed at Ypres in 1914. Stuart was our only one left. After nine months he is fit for light duty, though slightly maimed in vision, and it is to Alec Seabrooke that we owe it all."

"—What need for excuse for the tears;
—What can be the measure of the grief
—for that dear head,—so kind,
so unfailing, so beloved?"

Another letter—"You must be very proud of your boy and you will indeed feel sure that there have passed very few through the world who have been

more loved than he has been. Sometimes it seems strange that the best and brightest should go first, those who could have done so much for others, but we who are left behind must try and believe that it is not *frustration*, but *promotion*, that those who have learnt this world's lessons most quickly are gone to more perfect work under happier conditions elsewhere."

"He did so much to lighten the pain of the badly wounded men and always had a cheery word."

"Nothing could have exceeded the patient care and skill which he devoted to me when I was in Guy's Hospital with wounds. I have heard of the good work he did in Mesopotamia."

In November, 1915, the Rawal Pindi Hospital was transferred to Mesopotamia, and there, as a result of overwork and unsanitary conditions, Alec Seabrooke met his death. It is impossible with a pen to do justice to the character and attainments of such a man as "Puppy" Seabrooke ("He was always 'Puppy,' wasn't he?" "A dear old cheery, hearty friend"). His memory will live evergreen in the hearts of his friends, who, in their grief, know that although cut off in the prime of his manhood, "Puppy" has done more than any of us to promote happiness and good feeling in this world. A man of fine physique and an appearance which showed his strong character, it is no exaggeration to say that he was the most all-round popular man of his time at Guy's. His sympathy was sensible, practical, and self-sacrificing. He frequently visited his old patients, too feeble to come to hospital, in their homes, to treat their maladies, to give advice and assist them in their financial difficulties. They are not unmindful of his God-given gifts, for they say:—

"I have never forgotten his kindness to me when in Guy's Hospital."

"I inquired about Dr. Seabrooke and was told he was at the war. He was spoken of so highly, and all seemed to miss him so much."

"I call to remembrance many happy thoughts of Mr. Seabrooke, ever thinking of him as a fine type of English manhood, graceful, gentle, kind, and true.'

"I am confident that had he had the ordering of his own farewell from this world, it would have been such as it was—giving his life in a great and noble cause. For by the sacrifice of such lives, England is able to hold all the great liberties we enjoy."

We have heard that while in France he wrote letters of condolence to the bereaved relatives of our fallen soldiers and placed flowers sent from home on their graves.

As a natural part of his great unselfishness, "Puppy" Seabrooke corresponded regularly with his friends. In his last letter referring to the gallant death in Egypt of one of his colleagues at Guy's, he said: "He was a good fellow, and if one has to die, it is some consolation to one's people that one died doing one's duty." Duty, self-sacrifice, and a consideration for others were Seabrooke's watchwords. His last great gift to us, his proud but sorrowing friends, is the living memory of his *character*. May that immortal treasure help us in the trials and struggles of this life! W. E. T.

Roll of Honour.

Capt. A. Seabrooke, R.A.M.C., Capt. D. W. Smith, R.A.M.C.

Mentioned in Despatches.

The names of the following medical men are mentioned in despatches received from General Sir Charles Monro, dealing with the operations of the Mediterranean Expeditionary Force, and from General Sir John Nixon, dealing with the operations in Mesopotamia, under the command of Major-General C. V. F. Townshend, C.B., D.S.O.—Colonel R. H. Luce, V.D. (T.F. Res.), General Headquarters' Staff.

R.A.M.C.—Lieut.-Colonel L. Humphry.

Temporary Major (temporary Lieut.-Colonel) H. Richardson, Scottish Horse, Mounted Brigade Field Ambulance (T.F.).

R.N. Medical Units.—Temporary Surgeon G. Hamilton, R.N.

Honours for Guy's Nurses.

Mentioned in Despatches.

SIR DOUGLAS HAIG'S DISPATCH, June, 1916.

Miss H. Suart, Q.A.I.M.N.S., Acting Matron. Guy's July, 1895, to February, 1900.

Miss A. B. Nunn, Q.A.I.M.N.S., Assistant Matron. Guy's, February, 1903, to October, 1906.

Miss L. E. Jolley, Q.A.I.M.N.S.R., Acting Sister, Guy's, February, 1903, to June, 1906. Sister, ditto, September, 1906, to May, 1908, and 1909 to 1910.

Miss M. F. Beardshaw, C.H.R., Acting Sister. Guy's, January, 1910, to June, 1913. Sister, ditto, to August, 1914.

Miss E. Fraser, C.H.R., Acting Sister. Guy's, August, 1902, to September, 1905. Sister, ditto, October, 1906, to May, 1908.

SIR JOHN MAXWELL'S DISPATCH, EGYPT, March, 1916.

Miss M. Willes, Q.A.I.M.N.S., Acting Matron, Hospital Ship. Guy's, January, 1904, to January, 1907.

Miss Grace Corder, Q.A.I.M.N.S.R., Acting Sister. Guy's, May, 1899, to February, 1903.

ROYAL RED CROSS—SECOND CLASS.

Miss K. E. G. Taylor, T.F.N.S., Sister, 1st Eastern General Hospital, Cambridge. Guy's, September, 1896, to April, 1900.

Miss A. R. I. Lowe, Q.A.I.M.N.S. for India, Temporary Nursing Sister. Guy's, January, 1903, to May, 1906.

Pass List.

University of Oxford.

FIRST EXAMINATION FOR THE DEGREE OF BACHELOR OF MEDICINE.

At the Examination held recently the following candidates were successful:—

Human Anatomy and Human Physiology..—H. G. Burford.

SECOND EXAMINATION FOR THE DEGREE OF BACHELOR OF MEDICINE.

Materia Medica and Pharmacology.—C. W, W. Armstrong, W. Gover.

Pathology.—C. W. W. Armstrong, W. Burridge, W. Gover,

Forensic Medicine and Public Health.—T. E. Micklem, W. Burridge, J. M. H. Campbell.

Medicine, Surgery and Midwifery.—T. E. Micklem, J. M. H. Campbell.

University of London.

SECOND EXAMINATION FOR MEDICAL DEGREES. PART II.

The following candidates were successful in passing the recent Examinations:—T. E. Bonar, E. F. Kerby, G. F. Peters, R. S. Ralph, W. H. Simmons, H. W. Southgate, B.Sc., R. W. Warrick, S. T. Wong.

Royal Colleges of Physicians of London and Surgeons of England.

At the Second Professional Examination in Anatomy and Physiology, held on June 29th and 30th, and on July 3rd, the following candidates were successful:—R. C. B. Ledlie, R. G. Mayer.

Society of Apothecaries of London.

At the last Examination the following candidates passed in the subjects indicated.

PRIMARY EXAMINATION. PART II.

Anatomy.—J. G. Barrie, W. H. Cellier, G. Hume, G. Massie, W. W. Payne, C. H. St. John.

Physiology.—W. H. Cellier, G. Hume, G. Massie, W. W. Payne, C. H. St. John.

Medicine.—H. T. Lamb, Sections I. and II.

Forensic Medicine.—A. L. Malabre.

Midwifery.—H. T. Lamb, A. L. Malabre.

The Diploma of the Society was conferred on H. T. Lamb and A. L. Malabre, entitling them to practise in Medicine, Surgery and Midwifery.

Examining Board in England by the Royal Colleges of Physicians of London and Surgeons of England.

At the Quarterly Examination in Practical Pharmacy, held on July 6th and 7th, the following candidates were successful:—J. A. M. Alcock, N. A. H. Barlow, M. Hall, M. A. R. Khalifa, N. H. S. Maelzer, A. Y. Massouda, R. S. Millar, J. O. R. Montocchio, A. R. Neckles, A. G. Ord, G. B. Tarring, R. R. Traill.

More Humours of Regimental Work.

THIS place is a depot and, in addition to new recruits, the unfit from Overseas Battalions return after discharge from hospital. Among these I have come across veterans sent back from garrison troops in Egypt, Malta, and other stations. One old fellow had been sent back from Alexandria almost as soon as he arrived there on account of age and general debility. Thinking to console him, I said, "Well, you had a nice trip out to Alexandria."

"Not me first time there," he replied.

"When were you there previously?" I inquired.

"During the bombardment, sir."

This will give you a shrewd idea as to the age of this ancient warrior.

I was vaccinating a batch of recruits and asked one of them when he was last vaccinated.

"Not since I had my senses, sir."

I do not think that he was casting any reflections on the advantages or disadvantages of vaccination.

Another recruit was ill in a barrack room. He was lying on his bed moaning, groaning, and apparently in great agony.

"What is the matter, my boy?" I said.

"Please, sir, I have a phospherescent stomach."

Apparently he had had some form of phosphorus poisoning in civil life, and now had an attack of colic. He also informed me that these attacks occurred monthly.

I heard of two Cockney battalions in adjoining trenches. One Tommy shouts to another in the next battalion, "Hey, Bill, 'ave yer got any laices?"

"Naw, these are clean trenches."

"I means boot laices; not them laices."

An officer consulted the M.O. of his regiment. "I say, Doc., I've got a lot of little white things in my head that bite, and I want your advice."

The keen M.O. immediately gave minute instructions as to the correct form of treatment, etc.

"But, Doc., I notice that you also have similar little white things in your head."

The anger and amazement of the Medical Officer can be left to the imagination.

"I mean your teeth, Doc."

T. G. D.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

The Value of Starvation in the Treatment of Diabetes Mellitus.

CLINICAL LECTURE BY E. P. POULTON, M.D.

(Continued from page 227.)

Allen's treatment of diabetes by starvation is based directly on animal experiment. These experiments have disclosed two fundamental facts. Firstly, there is the similarity to human diabetes of the experimental diabetes of partially depancreatised dogs, and secondly, there is the demonstration of the success of starvation in treating the animal condition.

You will remember that some of these animals were starved to begin with, and later were given protein and fat in small quantities, so that they remained sugar-free. They became thin, but were still vigorous, and remained alive indefinitely. Other animals were allowed to eat as much food as they wanted, and though they throve to begin with, they eventually wasted in spite of eating enormous amounts of food, and ultimately died in cachexia.

The moral of these experiments when applied to human diabetes is, "treat your patient early, and, if you can keep him sugar-free, see that his weight remains low."

This analogy between human diabetes and the experimental form should give us a more hopeful view of the former disease than is usually held at the present time. A dog rendered diabetic by partial pancreatectomy is not suffering from any diseased internal organ. The part of the pancreas remaining behind is perfectly healthy. It is only not present in sufficient amount to provide all the internal secretion necessary to keep the body at its normal high rate of metabolism. If the latter is diminished by treatment the pancreatic secretion will be sufficient, and the animal will be kept alive indefinitely. Similarly it is possible, that in human diabetes the functioning part of the pancreas may be perfectly healthy, though small in amount. In such a case life will only be terminated through bad treatment. However, in other cases it is possible that some pathological process will gradually invade the whole gland, and then this case will gradually get worse and die in spite of treatment. It is impossible to say how common the latter type of case is, but there is a general impression that the vast majority of cases in diabetes do not tend to progress if they can be kept sugar-free from the start.

When this new treatment was first of all tried in America, it met with the greatest possible enthusiasm. In fact some of its exponents made statements with reference to it, that can only be described as picturesque exaggerations. For instance—"I am coming to believe that coma no longer represents the culmination of the disease, but is an avoidable accident." Still, although I am afraid that in many of the severest types of diabetes the treatment will be found unsuccessful, it was only when I came to compare the results obtained at Guy's by the new treatment with cases treated previously by the older methods, that I properly realised what a great step forward this treatment really is.

Table I gives a summary of the eleven cases treated at Guy's just previously to the introduction of Allen's treatment. Three of these, M.T. (1), H. (1), F. (1), were treated later on by the new method. With the exception of two cases, M.T. (1) and S., no case was at any time sugar-free, and all of them went out passing about the same amount of sugar as they were passing on admission to the hospital. Of the two cases which might be regarded as partial successes, M.T. (1) (the case reviewed in the last lecture) was later on successfully treated on the new lines, and S. was a mild case, chiefly suffering from constipation, who would almost certainly have been kept sugar-free by the new treatment.

Table II gives the results where Allen's treatment was used. There are 5 complete successes (F., M.T. (2), McS., T.B., Be). By that I mean that with treatment the patients could apparently be kept free from sugar indefinitely. Of these cases M.T. (2), appears in table I as a partial success by the older method, and McS was an old lady in Patience suffering from arteriosclerosis and gangrene, and the glycosuria was not the real cause of her trouble, and so its removal was not of any benefit to her. Perhaps the most brilliant success was that of Be. in Samaritan (Table III). His sugar, 220 gms. per diem, disappeared completely after one day's starvation, and his gangrene and sepsis cleared up at once. This leads me to emphasise what seems to be an undoubted fact, that the complications of diabetes, such as carbuncles, abscesses, pruritus, neuritis, clear up rapidly with this treatment, and probably in future surgery will be found to be merely of secondary importance in these conditions. This is of great importance, as the chief difficulty of surgery in diabetes is the anæsthetic, as general anæsthetics are very apt to produce coma.

Two cases, H (2), and F.M. were partial successes. H (2) is interesting as she shows definite progress of the disease since earlier unsuccessful treatment when she was in hospital for the first time (see Table I). Table IV shows the difficulty we had in getting her free from sugar on the second occasion. On the first occasion she was practically free after three days treatment, starvation not being used. On the second occasion it took four days starvation, and six days reduced feeding before she was sugar free. She was a disappointing case, as she did well to begin with, but after the first eighteen days it was found increasingly difficult to keep her sugar free, and she was eventually allowed to go out of hospital, passing much less sugar, however, than when she came in.

F.M., did well until quite at the end, when sugar reappeared in the urine when she was taking food. It could always be removed by a day's starvation, but rapidly came back again.

There were 5 failures (B., A.J., C H., H.C., A.W.). Four of them were hardly examples in which the treatment had failed, because in these cases it was not carried out completely. The difficulties were that either the patients were unduly distressed by it, or refused to undergo it, or were suspected with good reason of taking other food surreptitiously. It is always a difficulty in hospital to stop a patient taking extra food when he wishes to do so. If there is a good prospect of keeping a patient sugar-free by treatment, he should be given previously to understand that the length of his life depends upon his perseverance, and this will be of great help to him.

The case of H.C. merits further consideration. He had not been treated in any way before

TABLE I.—DIABETES TREATED AT GUY'S IN 1915 BY OLDER METHODS.

Case.	Sex.	Age.	Average Sugar Output on first 4 days in Hospital. gms.	Acidosis.	Average for last 4 days. gms.	Date of Admission.	Date of Discharge.	No. of Days Sugar-free. *		
E. ...	M	42	174	+	196	Sept. 25	Mar. 15	0	0	Trace.
B. ...	M	25	5·5	?	4·7	April 12	May 4	0	1	Albuminuria.
R. ...	M	19	257	+	341	April 15	May 12	0	0	
M. T. (1)	F	9	133	+	6·6	Feb. 17	June 20	7	5	
S. ...	F	13	37	+ slight	3	May 29	Aug. 14	5	17	Mild case. Constipation.
L. ..	M	47	43	0	27	June 8	June 30	0	0	In Samaritan.
H. (1) ...	F	26	17	+	112	July 13	Sept. 29	0	0	
Ba. ...	F	19	206	+	111	Aug. 16	Oct. 10	0	0	Threatening coma. Recovery.
Bu. ...	M	8	79	+ slight	56·6	Oct. 14	Nov. 12	0	0	
F. (1) ...	M	56	30·6	+ slight	25·1	Oct. 25	Nov. 23	0	0	Slight cerebral hæmorrhage.
N. ...	F	22	141·5	+	? (coma)	Nov. 15	Nov. 28	0	0	

TABLE II.—DIABETES TREATED AT GUY'S BY ALLEN'S METHOD.

Case.	Sex.	Age.	Average Sugar Output first 4 days in Hospital or just before treatment.	Average last 4 days. gms.	Admission.	Discharge.	No. of Days Sugar-free *		
F. M. ...	F	40	7·25 %	6·4	Mar. 10	May 14	15	12	
F. (2) ...	M	56	25·1 gms.	2·2	Nov. 23	Dec. 21	10	12	
M. T. (2)	F	9	103	0	Nov. 15	Feb. 12	45	6	
B. ...	M	50	4 days' starvation for acidosis.		Distressed.	Not sugar-free.			In Samaritan.
H. (2) ...	F	26	260	51	Jan. 15	April 8	14	3	
McS. ...	F	70	4·7 %	0	Arterio-sclerosis; no benefit.				In Patience.
A. J. ...	M	29	292	201	Jan. 29	Feb. 16	0	0	Refused treatment. Took
C. H. ...	M	20	173	192	Feb. 5	April 4	0	0	? ,, extra food.
H. C. ...	M	20	135	(coma) 45·4	Feb. 23	Feb. 26	0	0	
T. B. ...	M	40	Starvation at home	0	Feb. 25	Mar. 21	20	6	
A. W. ...	M	36	119	28·5	Mar. 6	April 14	8	4	? Took extra food.
Be. ...	M	44	8·5	Trace.	Mar. 11	April 27	5	2	In Samaritan. Gangrene.

* This column indicates the number of days on which only a trace of sugar was passed.

admission, but had lived on ordinary food. On admission his alveolar CO_2 was 2·8 per cent. (normal 5–6 per cent.). He was at once starved. The first day the sugar output was 135 gms., on the second day it was 97 gms., and on the third day it was 45·4 gms., and on this day he went into coma; a value of 0·9 per cent. was found for the alveolar CO_2.

There is no doubt that he was on the downgrade on admission, as his alveolar CO_2 was low, but whether this was hastened by starvation is difficult to say. Joslin has recently adopted the plan of dealing with long standing cases by more gradual treatment. He first reduces their diet by cutting off all fat, later by cutting off protein, and finally carbohydrate. I think it is

TABLE III.—B., aged 44. In Samaritan. Gangrene and Sepsis of Forearm, which cleared up with treatment, by starvation, etc.

Diet.	Aceto-acetic Reaction.	Sugar.
	0	9 % 220 gms.
Starvation 1 day	Slight	42 gms.
Greens, butter, eggs, 1 day	"	0
+ Diabetic bread and 2 oz. meat	—	0
"	—	0
"	—	0
"	—	0
"	—	0
"	—	Trace
"	—	Trace

TABLE IV.—E. H., aged 26.

	Diet.	Sugar.	
		gms.	
July 21, '15		37	First admission.
22	Vegetables and eggs	7·1	
23	" " "	3·8	
24	" " "	5·3	
25	" + diabetic bread	Trace	
26	"	25, etc.	
Jan. 16, '16		353	Second admission.
17	Starvation	54	
18	"	9·1	
19	Greens and butter	5·0	
20	"	2·9	
21	"	40	
22	" + carrots & turnips	24·7	
23	" "	27·3	
24	" "	26·5	
25	Starvation	10·7	
26	"	3·1	
27	"	0	
28	Greens	0	

Difficult to keep sugar free.

TABLE V.—MODIFIED VON NOORDEN TREATMENT.—M. T. (1).

Date.	Diet.			Sugar.	Acidosis.		
	Carbohydrate.	Cals.			Aceto-acetic Reaction.	Ammonia.	
						N. gms.	Index.
	gms.			grms.			
Mar. 13	82	?	Bread 4 ozs.	—	not noted	—	—
14	"	—	Potatoes 2 ozs.	40 +	"	—	—
15	"	—	Milk 6 ozs.	37 +	"	—	—
16	"	—	——	40 +	"	—	—
17	"	—	——	88	"	—	—
18	"	—	——	68	+	·30	6·2 %
19	? 6	Circ. 500	Vegetables and eggs	3·1	++	·47	—
20	"	" "	Vegetables	1·2	++	—	—
21	++	" 1500	Potatoes	17·6	++	·44	12·8 %
22	++	" "	Potatoes	37·3	++	1·24	18 %
23	? 6	" 500	Vegetables	9·6	+	1·05	26 %
24	? 6	" "	Vegetables	Trace	less +	1·0	27 %
25	15	—	Strict diet and 10 ozs. milk	34	+ slight	—	—
26	"	—	" "	36·6	+ slight	·46	11 %
27	"	—	" "	91·5	not noted	—	—
28	"	—	" "	96·6	+	—	—

present an open question whether it is possible to reduce acidosis more by this means. It may well be the case.

The other point that requires consideration is the question of giving sodium bicarbonate. I think there is much to be said for the view that it is better to combat acidosis by preventing the formation of the acetone bodies in the organism (by starvation and diet) rather than by facilitating their excretion by giving large doses of alkali.

But I think Joslin goes too far when he wishes practically to give up alkali altogether. There are, no doubt, disadvantages in giving large doses of alkali (the production of œdema, etc.), and in this case it was hoped that starvation would be sufficient, and the alkali in large doses was not given until it was apparent clinically that coma was coming on. I think it would be better in future always to give alkali in large doses by the mouth, *i.e.* 1 to 2 ozs. in the day, whenever the alveolar CO_2 is below 3 per cent., and keep on with the treatment until it shows a definite rise, and then gradually diminish the dose, and finally give it up altogether.

Joslin has recently published certain statistics of cases of diabetes treated on the new lines with the case mortality.

125 cases were treated with starvation at the New England Deaconess Hospital, from May, 1914 to December, 1915. Of these cases 14 were dead in the early part of the present year. Analysis of these 14 cases shows that six died of intercurrent infection, or independent complications; seven cases died owing to incomplete treatment. In some of these cases the treatment by starvation was incomplete, *i.e.* the patients stopped treatment before they had become sugar-free, while in other cases the treatment was stopped after they had left the hospital. One case (No. 740) is of special interest, as he was looked upon as a great success, when he left hospital after treatment to start with. He was a severe case, who became sugar-free on the 4th day of starvation, and he left the hospital sugar-free. He resumed his work, but although he followed his diet with considerable care, he was probably seldom sugar-free outside. He gradually lost strength and gave up work, and when he was finally pursuaded to come into hospital again four months later, he died almost immediately with most of the symptoms of coma. It is a case of this kind which most probably has led Joslin to make this allusion which seems to run counter to his other enthusiastic remarks, viz., "that in no severe case has there been any decided gain in tolerance, though there have been deceptive apparent gains."

So far as my experience goes I can fully bear out this statement. In the cases F.M. and H. (2) (Table III.), the treatment was successful at first and seemed to fail later on, and even before they went out of hospital they were passing sugar on a diet which was about a minimum for the bodies' needs. In the light of these facts it would be interesting to know how many of the 125 patients that were at one time treated successfully by Joslin, are now sugar-free. I myself very much doubt the ultimate efficiency of this treatment for the worst cases.

Joslin's last fatal case was a man who had had diabetes 29 years. The fasting treatment was begun very gradually. On the 9th day of his fast there was still 17 gms. of dextrose in the urine, and death occurred not long afterwards. This is a complete failure, because not only did he not become sugar-free, but the treatment apparently led to his death. The result may possibly have been due to the length of time that the patient had had the disease.

At present, I think, we must look upon the results of this treatment in the severest cases, as rather uncertain, though I have little doubt that in the great majority of them temporary benefit will be obtained, because acidosis is diminished.

The practical application of the starvation treatment will now be discussed. After the patient has been made sugar-free by starvation, Allen advises giving him small increasing amounts of carbohydrate or protein food, and leaving it to the discretion of the physician as to which of these foods should be given in the first place. Later, fats are added. Joslin advises increasing protein and fat together but to begin carbohydrate feeding one day earlier than protein feeding. This method has the advantage, that the patient is given a considerable bulk of food on the very first day, consisting of vegetables containing about 5 per cent. carbohydrates, and this helps to satisfy him. The gradual increase in carbohydrate is carried out, both by increasing the amount taken in the day, and in giving vegetables richer in carbohydrates. Provided these rules are followed, the kinds of vegetables should be frequently varied so as to prevent the patient getting tired of the diet. Joslin arranges vegetables in a list as follows:—

5 per cent. carbohydrates—lettuce, cucumber, spinach, asparagus, rhubarb, endive, marrow, sorrel, beet, greens, celery, tomatoes, brussels sprouts, watercress, seakale, cauliflower, cabbage, radishes, leeks, string beans, broccoli.

10 per cent. carbohydrates—turnips, beets, carrots, onions, mushrooms.

15 per cent. carbohydrates—green peas, artichokes, parsnips.

20 per cent. carbohydrates—potatoes, boiled rice, boiled maccaroni, green corn.

Later on fat is added, but only in sufficient quantity to prevent further loss of weight. Although there is no evidence that in the diabetic organism sugar is formed from fat, it is possible to bring back a glycosuria by giving too much fat, possibly owing to increased metabolism; further acidosis is increased.

The following is treatment in full as described by Joslin:—

SUMMARY OF TREATMENT.

Fasting.—Fast until sugar-free. Drink water freely, and tea, coffee and clear meat broth as desired. In very severe, long-standing, and complicated cases. without otherwise changing habits or diet, omit fat, after two days omit protein, and halve carbohydrate daily to 10 grams, then fast.

Carbohydrate tolerance.—When the 24 hour urine is sugar-free, add 150 grams of a 5 per cent. vegetable, and continue to add 5 grams carbohydrates daily up to 20, and then 5 grams every other day, passing successively upward through the 5, 10, and 15 per cent. vegetables, 5 and 10 per cent. fruits, potato and oatmeal to bread, unless sugar appears or the tolerance reaches 3 grams carbohydrate per kilogram body weight.

Protein tolerance.—When the urine has been sugar-free for two days add 20 grams protein (3 eggs), and thereafter 15 grams protein daily in the form of meat until the patient is receiving 1 gram protein per kilogram body weight, or if the carbohydrate tolerance is zero, only ¾ gram per kilogram body weight.

Fat tolerance.—While testing the protein tolerance, a small quantity of fat is included in the eggs and meat given. Add no more fat until the protein reaches 1 gram per kilogram (unless the protein tolerance is below this figure), but then add 25 grams daily until the patient ceases to lose weight or receives not over 40 calories per kilogram body weight.

Re-appearance of sugar.—The return of sugar demands fasting for 24 hours or until sugar-free. The diet is then increased twice as rapidly as before, but the carbohydrate should not exceed half the former tolerance until the urine has been sugar-free two weeks, and it should not then be increased more than 5 grams per week.

Weekly fast days.—Whenever the tolerance is less than 20 gms. carbohydrate, fasting should be practised, one day in seven; when the tolerance is between 20 and 50 gms. carbohydrate, upon the weekly fast day 5 per cent. vegetables and one-half the usual protein and fat are allowed; when the tolerance is between 50 and 100 gms. carbohydrate, the 10 and 15 per cent. vegetables are added as well. If the tolerance is more than 100 gms. carbohydrate, upon weekly fast days, the carbohydrate should be halved.

It will be as well now to consider briefly the methods of treatment used for diabetes before Allen's researches. In 1796, Rollo, an English army Surgeon, restricted the diet of diabetics to animal food, and thus initiated the ordinary "diabetic diet." By itself this method is insufficient as it takes no account of the tolerance most patients possess for a certain limited amount of carbohydrate, and so it is usual to add carbohydrates to this diet. However, in other ways it is unsatisfactory because the diet contains excessive quantities of protein and fat, and the former itself produces sugar, and so causes glycosuria in severe cases.

Nannyn employed occasional starvation days to clear up a resistant glycosuria, to improve tolerance, and ward off coma. Allen's treatment is the development of this idea.

In Von Noorden's "Oat-cure" a somewhat similar method is employed. Patients were either starved, or given a very light diet of eggs and vegetables, of low calorie value. Some tolerance for carbohydrate was gained. Then the patients were given large amounts of oatmeal for one or two days, and it was found that much more carbohydrate was utilised by the body, than was the case before. Subsequently some more vegetable and egg days were given, and glycosuria was often entirely abolished.

Von Noorden regarded the oatmeal days as the important part of the treatment, whereas it is now evident that it is the preliminary starvation or low diet that is the essential thing.

Table V shows the effect of this treatment on the case M.T. On the first occasion she was in hospital, the sugar was reduced to a trace by the 6th day of the treatment, but it subsequently rose again, and became about the same as before.

Much controversy has taken place, as whether the oatmeal is specific in its action. A number of writers have denied this, and have described wheat-cures, milk-cures, and potato-cures. It has been further pointed out that oatmeal starch and wheat starch produced the same

effect, and that for oatmeal to produce the most favourable result it must be boiled, and not used dry in the form of oat-cakes. If this is the case, the beneficial effect of boiled oatmeal or porridge must be in its bulkiness, which prevents so much being eaten at one meal as would be the case if it were taken in the form of dry cakes. The carbohydrate would tend to be spread out over the day, and thus better utilised than it would be if it were eaten all at the same time.

Another treatment has been used for those cases of diabetes whom it was found impossible to keep sugar-free. These patients have been given carbohydrate with the object of warding off coma.

The following are my conclusions with regard to the value of the starvation treatment in diabetes.

It is an excellent treatment for mild cases, because the patient is rapidly made sugar-free, and this gains confidence to start with. The remainder of his time in hospital is spent in finding out what his tolerance is and in arranging his diet, and in many cases in teaching him to test his own urine for sugar.

It is an essential method of treatment for cases suffering from septic and other complications of diabetes.

The advantages of the treatment are that no medicines are necessary, and no alkalies as a general rule, and that diabetic bread need not be bought.

In the severe type of case it is best to try the treatment for a time, because it is impossible to tell whether a patient can or cannot be kept permanently sugar-free until trial has been made. In any case the treatment will be of advantage to the patient owing to the diminution of the acidosis. Patients treated successfully are not found to have any craving for carbohydrate. It is possible that in very long standing cases the treatment may prove unsuitable.

The great disadvantage of this treatment is that patients often feel much less vigorous during the period of starvation and continued low diet than they do with a more liberal diet, even though they are passing sugar. They may feel incapable of doing their work, and unless there seems a reasonable chance of benefiting the patient permanently, it will probably be better to forego the treatment when this is the case.

However, in this type of case—the severest of all—a starvation day at periodical intervals will be of use in temporally diminishing acidosis and raising tolerance.

Just recently Allen has published a communication on the effect of muscular exercise combined with his treatment. This is a subject that has often been discussed before. The general impression, as stated by Von Noorden, is that in mild cases of diabetes exercise improves the condition and lessens the glycosuria by causing an increased utilisation of carbohydrate. However, in severe cases with considerable acidosis, there is no improvement in the glycosuria, and coma may readily be brought on.

Allen considered that if in a severe case of diabetes the acidosis had been almost abolished by this treatment, exercise might be beneficial in increasing the utilisation of carbohydrate, and there would be no fear of bringing on coma. As in his previous work, this view was first tested by animal experiment. A partially depancreatised dog had glycosuria on a diet containing 100 gms. of bread. When made to take severe muscular exercise on a tread mill, there was no glycosuria, even when the diet contained 200 gms. of bread.

This view is, on the face of it, a very reasonable one, and before hearing of this particular work of Allen's, the effect of exercise had been tried in the case of M. T. The apparent effect was to produce glycosuria, which disappeared as soon as the patient was put to bed. It was only later that it was discovered that, when the patient was up and about, she had been in the custom of getting food from other patients, and we were evidently misled on this account.

Allen states that if strong patients are made to take exercise during their initial fast, the length of the latter is shortened; he also finds that it lessens the tendency to glycosuria and acidosis. The blood sugar percentage rapidly falls after ½–1 hour's active exercise, and this treatment is excellent for those patients who suffer from persistent hyperglycæmia without glycosuria, whose kidneys have a "high leak point" according to Graham. With exercise patients can tolerate more food than before, without producing glycosuria. Appetite increases, but less than the power to satisfy it, owing to the increased tolerance for food.

Allen suggests that patients with a low carbohydrate tolerance will be specially benefited by this treatment, and particularly children and tuberculous diabetics. He emphasises the fact that the value of exercises is limited, and in any case less important than rules of diet. Exercises should be vigorous and of short duration, and not long and fatiguing. The types of exercise he has used have been running up and down

stairs, turning somersaults, and pushing about a large "medicine ball." The best time for giving the exercises is after a meal that may lead to glycosuria.

This seems a very suggestive line of treatment which may lead to valuable results.

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Joslin Brigham and Hornor.—An Analysis of fourteen cases of Diabetes Mellitus unsuccessfully treated by fasting. Boston Med. and Surg. Jour. (1916), 174, pp. 371 and 425.

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Appointments.

Royal Navy Medical Service.

The following appointments have been notified:—

Surgeon G. B. Cockrem to H.M.S. *Tamar*.

Temporary Surgeon A. H. Harkness to H.M.S. *Vivid* for R.N. Barracks.

F. C. Endean to H.M.S. *Dido*.

Temporary Surgeon R. H. C. Pryn to R.N. Hospital, Plymouth.

Royal Army Medical Corps.

Temporary Lieutenant to be temporary Captain:—E. R. Fothergill.

To be temporary Lieutenants:—J. A. B. Hammond, C. C. Holman, P. D. Magowan (whilst employed at the Lord Derby War Hospital).

Temporary Lieutenants relinquishing their Commissions:—W. R. Morris, G. W. Dryland.

Territorial Force, R.A.M.C.

Wessex Field Ambulance:—Capt. P. R. Boland, from attached to other Units other than Medical Units, to be Captain.

Welsh Border Mounted Brigade Field Ambulance:—C. Jephcott, M.B., to be Lieutenant.

Eastern General Hospital:—Capt. W. Tyson, M.D., is restored to the establishment.

West Lancashire Division Sanitary Section:—Lieut. A. Reid to be Captain.

Canadian Army Medical Council.

S. G. Graham to be temporary Lieutenant.

Civil.

L. Bromley, M.B., M.C. Cantab., F.R.C.S. England, has been appointed Assistant Surgeon to Guy's Hospital.

W. W. Cook, M.R.C.S., L.R.C.P., has been appointed Medical Referee under the Workmen's Compensation Act, 1906, for County Court Circuit No. 2, and to be attached more particularly to the West Hartlepool County Court during the absence of Dr. A. E. Blackburn on military duty.

Three Interesting Cases of Spinal Injury.

Continued from page 929.

The following cases were under the care of Sir A. Lane in this Hospital:—

CASE 2.

Bullet wound in lower dorsal spinal cord. Complete paralysis below injured area; already much improved and continuing to improve under treatment.

R. E., aged 10, was admitted into Martha Ward under the care of Sir Arbuthnot Lane on October 6th, 1915, suffering from the effects of a bullet wound in the back. The history shows that patient was deliberately shot by a boy with an air gun, the bullet hitting her in the back about three inches to the left of the spinal column. Patient immediately fell to the ground and noticed a large quantity of blood escaping from a wound in her back. She was quite conscious and was unable to stand up, and when placed upon her feet, fell down again, her legs collapsing under her. She said she "felt dead" from a level just below the umbilicus.

On admission there was found a bullet wound about a quarter of an inch in diameter and about three inches to the left of the spinal column at about the level of the tenth thoracic vertebra.

A considerable amount of blood was oozing from the wound, and coughing seemed to expel more blood, and patient complained of pain in the chest and an acute and more severe pain in the left side. These pains were of a stabbing nature and ceased when patient was receiving the electrical treatment in the wards (to be described later); during the first three weeks these pains returned every day soon after the electrical treatment stopped, and then, quite suddenly, vanished and have not since re-appeared.

Reflex action was quite absent and sphincter control was completely lost; her urine dripped from her and she had no knowledge of when she desired to defæcate, neither could she tell when the act had been completed.

Dr. Hertz saw patient and reported on her condition as follows: "The complete *flaccid* paralysis, with loss of all motor and cutaneous reflexes, makes it almost certain that the spinal cord has either been shot through or has been so severely damaged (hæmorrhage and softening) that nothing could be gained by operation. I fear the prognosis is hopeless, though there may be some slight improvement. If, as is possible, a girdle pain develops later this could be relieved by dividing posterior roots, but otherwise I should advise against operation."

There was no movement of the bowels during the first two days after admission, and on the following

five days enemata had to be employed and on each occasion secured a successful result. During the first fortnight the bladder was washed out daily with a warm solution of boracic acid.

Shortly after admission Dr. Iredell suggested electrical treatment "with the idea that stimulation of the bladder might prevent the onset of cystitis."

A pad, moistened with warm saline, was placed just above the pubes and another similar pad on the left side. Galvanism, with reversals, was given so that she could feel it slightly on the side for 10 minutes. The strength of the current was about 10 milliamperes. The skin under the pads became very red after this treatment.

After the first application of the current the amount of urine was increased, and some sores which had developed on her back, heels, and toes began to dry up at once. Treatment was given daily for a fortnight, when it was possible to omit the bladder wash-out. When the treatment was omitted the quantity of urine was seen to diminish.

At the end of a week slight voluntary movement was noticed in the big toes, more marked in the left, and in a fortnight there was a slight extensor plantar reflex, also a plantar flexor reflex which had appeared before the extensor reflex.

The bowels were now being opened fairly regularly; aperients were needed about twice a week, and enemata only occasionally. Patient now knew when she desired to micturate, but could not control it, and also knew when she desired to defæcate. This was after 14 days of electrical treatment.

Girdle pains appeared for a few days, but were always controlled and improved by the treatment. On November 28th the knee-jerks were found, the left being stronger than the right. Electrical treatment was continued daily during December, and at the end of the month patient could sit up and move her toes, but power of sensation was still absent.

By the middle of January—treatment still continuing—voluntary movements of toes had increased and cutaneous sensation had now returned and patient could tell which foot or toe was touched. The control of the sphincters was still absent; after another month's treatment the sphincteric control had greatly improved; patient was developing double ankle clonus and back splints with foot pieces were applied to both legs. By the middle of March the sphincteric control had greatly improved; patient could now hold her urine for some time although at night she was slightly incontinent. The anal sphincter was completely under control.

About this time it was noticed that when the legs were being put upon the splints there were sudden spasmodic contractions of either the quadriceps extensors or hamstring muscles, or both in turn, which jerked the leg off the splint. These same sort of contractions were seen when any short sharp stimulus was applied, such as suddenly pulling out one of the hairs on the skin of the legs.

Since admission patient has received electrical treatment as follows:—From admission until the beginning of March, galvanism with reversals for 10 minutes daily; one pad was placed over the lumbar region of the vertebral column and the other just above the symphisis pubis. Since the beginning of March patient has been receiving labile galvanism with reversals to her legs for 10 minutes daily, the pad being applied over the sacrum; throughout the treatment the current strength has been about 10 milliamperes.

Since her admission patient has made considerable improvement and can stand now and walk for a few yards leaning for support on the arm of a nurse. She can semiflex her thighs and semiextend her knees, and these movements seem to require much concentrated effort. Dr. Iredell recently examined patient and made the following report on the electrical reactions of her muscles (lower limbs):—

MUSCLES.	FARADISM.	GALVANISM.
Calf ...	+ ...	K.C.C. > A.C.C.
Thigh ...	+ ...	K.C.C. > A.C.C.
Peronei ...	+ ...	K.C.C. > A.C.C.

Muscles hypersensitive.

Since admission patient has been taking Mist. Formaminæ Co. to prevent the possible onset of cystitis and any further complication.

In an X-ray examination of the position of the bullet, Mr. Shenton found it to be about 1½ inches below the skin.

From this short history it will be seen that the progress of the patient has been excellent; she is still in the ward, and hopes of further recovery are entertained.

W. H. GRACE.

CASE 3.

Crushing violence applied to cervical spinal cord. Paralysis soon followed by death.

W. L., aged 16, carman, admitted March 20th, 1916, for injuries to chest and shock. A loaded coal-cart, estimated to weigh 2 tons, passed over his back.

C.O.A.—Pulse 64; temperature 96·8°; respiration 24. Patient seemed to be suffering from extreme shock; he was somewhat drowsy, and was breathing quietly with his mouth open, each inspiration being accompanied by a further slight opening of the mouth. He kept his eyelids almost approximated. In the front surgery the pulse was extremely feeble, though perceptible at both wrists, and an injection of strychnine was given. Across the upper part of the chest corresponding to the upper three ribs there was bruising and scratching. There was marked tenderness on the left side just about the inner half of the clavicle.

Mr. Fagge examined patient about 10 minutes after arrival in the ward and suggested the possibility of fracture of the first rib upon the left side, and con-

sequent pressure upon the subclavian artery, because by this time there was no pulse in the left arm or in the left subclavian. Palpation for the subclavian artery was painful as there was considerable bruising at this point.

Further examination at a later period, when patient was less collapsed, revealed the fact that there was complete loss of sensation and motor power below a line drawn about an inch below the nipples—with the exception that most of the intercostal muscles were working—the upper four intercostals on the left side did not move and gave an appearance of flatness to the chest in this region.

There did not appear to be any area of hyperæsthesia between the paralysed and non-paralysed parts. Eighteen hours after admission Mr. Todd demonstrated that there was loss of cutaneous sensation along the medial espect of the left hypothenar eminence (twenty-four hours after admission cutaneous sensation had returned to this area).

The left upper limb was distinctly cooler than the right, and for some hours after admission patient complained of this and also of a feeling of "pins and needles" in his left hand. He was able to raise his left upper limb through about 40°, but could flex his elbow fully; all movements were sluggish. There was no impairment of cutaneous sensation or motor power in the right upper limb. Knee-jerks and ankle clonus were unobtainable. The plantar reflex was flexor on the left and unobtainable on the right side. The pupils were not markedly contracted and reacted briskly and equally to light. Priapism was present. There was retention of urine and constipation. A catheter was passed 12 hours after admission and about 18 ozs. of urine were drawn off; the urine was dark yellow. s.g. 1020, acid; albumin, blood, and sugar were absent, and there was no deposit. Patient had experienced no discomfort whatever from the inability to pass water and the catheter was passed easily and painlessly. The bowels were not open at all and when, after calomel (gr. ii.) and mag. sulph. (i oz.) were followed by an enema, the latter was returned quite clear.

On auscultation it was found that each inspiration was accompanied by a peculiar whistling sound; this was especially noticeable on the right side of the chest and the lower part of the left side. Pneumothorax was suggested as the cause of this.

No irregularity of the spine could be felt, nor could pressure upon the spinous processes discover any tender spot, and pressure or even jarring upon the head was not painful while the head was kept erect. Bending the head backwards and forwards or sideways was, however, attended by pain in the lower part of the neck. He was most comfortable when lying flat, but although restless and unable to sleep upon the night of admission until nepenthe had been administered, he complained of no actual pain except when his head lolled over out of the straight position or to one side; he was unable to straighten his head himself.

Patient was X-rayed on the day following admission. No injury to the spine could be detected, but a fracture of the left clavicle was found about its middle with very little displacement of the fragments.

Forty-three hours after admission patient began to breathe very badly, and warm oxygen was administered between 12.30 and 2.30 p.m., when it was stopped as breathing had greatly improved. Pituitrin was given at 1.50. About 4.45 p.m. on the same day the breathing again became much impaired, and the administration of warm oxygen was again begun. At 5.10 p.m., however, 48 hours after admission patient died of respiratory failure.

The post-mortem examination showed—At level of 7th cervical vertebra the cord was pulped over a very small area (one-eighth of an inch), so that the cord could be bent as though hinged at this point, and over an area of about two inches there was blood clot on the outer aspect of the dura. First three ribs on right side and left clavicle fractured. Fracture of 7th cervical vertebra—the laminæ only, the spinous processes were all intact—and the sternum was not fractured. Thirty-five ounces of blood-stained fluid in the chest. Bruising of the anterior mediastinum. Left subclavian artery torn where it crossed the first rib and plugged at sight of tear with blood clot. Old-standing pleurisy on left side. Catarrhal infection and large glands everywhere—upper right lobe of lung œdematous. Perisplenitis. A. Ll. S. PAYNE.

In conclusion we wish to thank Sir Arbuthnot Lane and his House-Surgeon, Mr. R. Curle, for permission to publish these notes; also Mr. W. E. Tanner for his valuable help in their preparation.

Change of Address.

Surgeon-Prob. A. H. Shelswell, H.M.S. *Achates*, c/o G.P.O.

Capt. J. A. Bouic, 7886, D Co., Artists' Rifles, O.T.C., Hare Hall Camp, Romford, Essex.

E. R. Boland, London Rifle Brigade, Fovant Camp, near Salisbury.

Temp. Lieut.- A. A. Greenwood., R.A.M.C., to No. 37 General Hospital, Salonika Force.

Temp. Surgeon R. H. C. Pryn, R.N., Hospital, Plymouth.

Lieut. C. C. Holman, R.A.M.C., 40th General Hospital, Indian Expeditionary Force, c/o India Office, S.W.

Lieut. W. E. Plummer, R.A.M.C., Valetta Hospital, Malta.

Capt. C. Sherris, R.A.M.C., No. 10, Field Ambulance, B.E.F.

Geoffrey Dunderdale, East African Medical Service, 23, Hartfield Road, Eastbourne (to be forwarded).

Surgeon G. B. Cockrem, R.N., to H.M.S. *Tamar*, Hong Kong, China.

R. Curle, Hon. Lieut. R.A.M.C., from College, Guy's Hospital, to Lady Carnarvon's Hospital for Officers, 48, Bryanston Square, W.

Breathing and Physical Exercises for use in Cases of Wounds in the Pleura, Lung and Diaphragm.*

BY CORTLANDT MACMAHON, B.A. OXON.

[Reprinted from the *R.A.M.C. Gazette*, June, 1916.]

THE exercises herein described have been used since the early months of the war on a large number of soldiers suffering from wounds of the pleura, lung, and diaphragm in St. Bartholomew's Hospital, Guy's Hospital, King Edward VII.'s Hospital for Officers, Princess Henry of Battenberg's Hospital for Officers, No. 1 London General Hospital, the Hospitals for Officers at 17, Park Lane, Dorchester House, and Londonderry House, Mrs. Hall Walker's and Mrs. Herbert Samuelson's Hospitals for Officers. The exercises are now set out in the hope they may be of general use in similar cases.†

The chief objects of the exercises are:—

(*a*) To prevent pleural adhesions forming and to break down existing adhesions by careful and gradual movements.

(*b*) To enable lungs, which have collapsed owing to pressure due to empyema, hæmothorax, and pneumothorax, to regain their normal condition.

(*c*) To reduce hæmothorax and pneumothorax.

(*d*) To restore the normal shape of the chest walls which have fallen in owing to collapse of the lungs.

(*e*) To assist the discharge of pus, where there is a drained empyema, by increasing the lung inflation.

(*f*) To improve the general condition by the tonic effects of the exercises, and especially to overcome breathlessness on exertion.

The early exercises can be carried out without moving the patient from his bed. At first an operator is necessary, who should, if possible, give the exercises daily for about a fortnight, after which time the patient can perform most of them for himself, and they should then be carried out night and morning half an hour before a meal. Great care must be taken that there is no exhaustion to the patient; only a few exercises should be given at each treatment, and after every six movements of each exercise a rest of at least two minutes should be given. It is advisable that only the first three movements of the exercises should be given for the first three days of the treatment, and, in a case of empyema that has recently undergone operation, the first four movements only should, as a rule, be given, until the drainage tube is removed, but when the temperature has remained normal for some days more extensive movements may be applied.

When the patient can be moved from bed the exercises should be carried out on a narrow couch or table. The free movement of the arms in all directions is essential. Special attention is called to the fact that all the exercises are carried out in a recumbent position, and that on the correct performance of the first three exercises depends the success of the others. Care must be taken that the upper chest is not drawn up nor the abdominal wall contracted during inspiration. These are the two great faults often found. Any protrusion of the abdominal wall during inspiration must also be guarded against. The time of commencement of the exercises, their extent and duration, are matters entirely for the physician or surgeon who has charge of the case. A marked improvement in the appetite, the sleeping, and the general appearance will, as a rule, be noticed within a week of the commencement of the treatment.

The exercises are as follows, it being clearly understood that only a few should be carried out at each treatment, and the advance through the exercises should be gradual and special exercises selected to suit the individual condition. Each particular exercise should be carried out eighteen times with a rest, as already stated, after each six movements of the exercise.

1. The operator places his hands on the side of the lower ribs level with the breast-bone. The patient should breathe in through the nose and the lower ribs should be felt to be expanding strongly. There should be as little movement as possible of the upper chest. When the fullest inferior lateral costal expansion is acquired, the patient should breathe out through the open mouth and the ribs should be felt to regain their normal position.

2. The abdominal wall should be contracted inwards and then allowed to recover its normal position, so that an in-and-out movement is made. (This is a physical and not a breathing exercise, and can be carried out twenty to fifty times.)

3. Combine the above movements, *i.e.*, the patient breathes in through the nose and the lower ribs are felt to be strongly expanding. The mouth is opened wide and the abdominal muscles slowly and strongly contracted, so that the air is driven from the lungs.

4. The same inspiratory movement, but the breath should be held and the abdominal muscles contracted in three to five deliberate movements before breathing out.

5. Bend the body laterally away from the side of the injured lung to the fullest extent, so that the uninjured side of the thorax is partially compressed. The patient is on his back and the head and feet are drawn round as far as possible. The operator

*See also the *Lancet*, October 2nd, October 9th, December 4th, 1915, and January 29th, 1916, and the *Brit. Med. Journ.*, January 22nd, 1916.

†For a description of cases treated, see paper by C. MacMahon in vol. xxxix of the *Proceedings of the Medical Society of London.*

should press over the uninjured lung with both hands and the patient should breathe, as before, in through the nose and out through the mouth, contracting the abdominal muscles as he breathes out. (When there has been considerable collapse of the ribs on the side of the injured lung, and especially when there has been an abscess in the lung, great care must be taken in doing this movement, otherwise considerable muscular discomfort will occur within a few hours. A certain amount of pain will necessarily be felt if there has been a serious collapse in the chest wall, but this can, of course, be relieved.)

6. The same movement and position, but the operator should press with his hands on the side of the uninjured lung with a pressure of thirty to sixty pounds and the patient should contract the abdominal wall, with the breath held, at first once, afterwards increasing by degrees to five times.

The following exercises are done with the breath held in :—

7. Grasp the wrists of the patient as the arms lie at the side of the body, the operator standing behind the patient. Draw the arms outwards and upwards to above the head, pull on the arms steadily when the arms are at their fullest extent, then relax the pull. The patient should then breath out quickly.

8. Arms as before. Bring them together in front and carry upwards to a right angle. Part the arms strongly backwards and horizontally.

9. The same exercise as the preceding one, but the arms are carried backwards at an angle of 45 degrees upwards.

10. Commence with the patient's arms above the head, with the palms of the hands facing each other. The operator grasps the arms between the wrists and the elbows and presses the arms strongly downwards, and when the elbows approach the sides the abdominal muscles should contract. Force the elbows into the side and make the patient breathe out strongly.

11. Grasp the right wrist of the patient with the left hand, carry the arm forwards, and bring it to a right angle with the body. The operator should then place his right hand well under the scapula of the patient and pull the arm backwards and downwards as the patient strongly contracts the abdominal wall. Changing the hands, do the same movement on the other arm of the patient.

12. When there is marked collapse of one side of the upper chest the body should be bent as in Exercise 5, and the wrist of the arm on the wounded side grasped, the arm being fully extended above the head. the patient should then pull the arm downwards with the elbow into the side and should strongly contract the abdominal muscles as the arm descends. The operator gently pulls against the patient. (This exercise is exhausting unless carried out very carefully; six movements are sufficient during the first few applications of it.)

The earliest time at which the exercises have been commenced has been fifteen days after the insertion of the drainage tube in cases of empyema and thirty-three days in cases of hæmothorax from the date of the wound.

Very great care must be taken that the instructions given above are carefully followed, otherwise harmful results might ensue.

When a patient suffering from the effects of a lung wound is convalescent, he should be encouraged to sleep on the side of the injured lung and when resting by day to adopt the body position described in Exercise 5. This will help recovery by enabling the injured lung to inflate more easily.

Papers by Guy's Men.

Lieut.-Col. C. H. Fagge, R.A.M.C. : The use of bone grafts,—*B.M.J.* (correspondence), July 15th, 1916.

W. Sampson Handley, M.D., F.R.C.S. : Jejunostomy and jejuno-colostomy.—*Ibid.*

H. A. Latimer, M.D. : Garlic in whooping cough.—*Ibid.*

Kenneth Goadby, M.R.C.S., L.R.C.P. Lond., D.P.H. Cantab. : An enquiry into the natural history of septic wounds.—*Lancet*, July 15th, 1916.

J. E. Spiller, L.D.S., R.C.S. : The restoration of lost parts by prosthetic apparatus.—*British Dental Journal*, July 15th, 1916.

Major A. J. Hull, F.R.C.S. Eng., R.A.M.C. : The Gangrene of War. Gaseous cellulitis or emphysematous gangrene.—*Lancet*, July 22nd, 1916.

T. Bird, M.R.C.S., M.A. Oxon. : The treatment of hæmorrhoids by interstitial injection.—*Ibid.*

R. H. Jocelyn Swan, M.S., F.R.C.S. : Traumatic and arterio-venous aneurysm. A third series of cases. Seven cases from the Royal Herbert Hospital.—*The British Journal of Surgery*, July, 1916 (continued from vol. iii., p. 496).

A. H. Miller, M.D. (Camb.), M.R.C.P. (Lond.) : On certain reactions of the tubercle bacillus to sperm oil and its constituents (with notes on the chemistry of sperm oil, by A. R. Smith, M.Sc. (Vict.), F.I.C.),—*Journal of Pathology and Bacteriology*, April, 1916.

Birth.

ADAMS.—At Lygon House, Cale Green. Stockport, on July 11th, the wife of Eustace H. Adams, M.R.C.S., L.R.C.P., of a daughter.

Deaths.

TICEHURST.—On July 7th, at Huntborne, Tenterden, Kent, Augustus Roland Ticehurst, M.R.C.S., L.R.C.P., aged 70.

SEABROOKE.—About July 1st, Capt. Alec Seabrooke, R.A.M.C., B.A., M.B., B.C. (Cantab.), M.R.C.S., L.R.C.P. Lond., aged 31.

F. A. K.

GUY'S HOSPITAL GAZETTE.

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Passim.

IT is an old topic to revive, but circumstances make it imperative. The difficulties which the GAZETTE has experienced in maintaining its modest sixteen pages have been many and various, for no sooner has one source of copy shown signs of reviving than another immediately and unaccountably begins to fail. Therefore has it been necessary to borrow from other periodicals far oftener than would be wished, insert matter which we readily agree is not up to the standard of former days, or, to put it more directly, eagerly to assemble any and every scrap of even passing interest which can be obtained. Open criticisms have been mercifully few, but, nevertheless, we are aware that in some quarters they have been spoken, while in others, the GAZETTE appears to be considered a failing, and, nowadays, an uninteresting unit of our organisation deserving of no assistance and only the briefest perusal. The Hospital Staff have come to our aid in the most willing fashion, and we would express our sincerest appreciation of their clinical lectures and lesser contributions. So ready has been their response in the past that we have ready reliance in their future assistance. Rather is it to the junior men, qualified and unqualified, that we would appeal. All will agree that the writing up of cases has become extraordinarily rare. Those few reaching us have been excellent, both in observation and interest, but how many have there been? We believe they could be easily counted on the fingers of two hands during the last six months.

So many times the request is answered by the excuse, doubtless meant in all earnestness, that the individual is no good at that sort of thing or, to come to the facts, he hesitates to put pen to paper. May we urge that neither the GAZETTE nor its readers expect more than a straightforward descriptive account in these instances.

It seems that the *case writer* has only to realize this situation, and at once overcome his reluctance to send us those notes which are so gladly published when we are fortunate enough to receive them.

WHILE on the subject, we would mention that of late there has again been a complete absence of letters from men on active service. Our best endeavours are made towards supplying them with such Hospital news as there is, and we should more than appreciate an occasional note as to their experiences and wanderings.

THE Residents' "Going-off" Dinner was held on Saturday, July 29th, in the College Dining Hall, and proved a great success. The guests numbered about 30, amongst whom we were glad to welcome Mr. Thompson, also

Mr. Pochin, who returned for a short spell from the Far East; and Mr. H. N. Eccles, who is shortly leaving for India to take up a post as radiographer.

After the toast of "The King," Mr. Medlock proposed the health of the President, Mr. Stallman, and voiced the general regret that his—the President's—term of office had come to an end, and wished him the best of luck in his new career, when he joins the Army, as shortly he intends doing.

Mr. Stallman replied, and asked us to drink to the health of the Vice-President, Mr. Medlock, whom, he was glad to say, was remaining on at Guy's as Resident Obstetrician.

Mr. Wilson proposed the "On-Coming Residents"—Mr. McEvedy, H.S. to Sir Arbuthnot Lane; Mr. Brogden, H.S. to Mr. Dunn; Mr. Phillips, H.P. to Dr. Hale White; Mr. Taymour, H.P. to Dr. Shaw; and Mr. Quesada, the Junior Charity—and told us how pleased he was to see that the spirit of the Empire had taken hold at Guy's, in that for the first time on record, Britishers as well as Englishmen, had been appointed as Residents.

Mr. Brogden replied shortly and cheerfully.

Mr. Curle then proposed the health of the "Visitors," welcoming especially Messrs. Thompson, Pochin and Eccles.

Mr. Thompson replied for all the visitors except Mr. Eccles, whom he considered was more than capable of answering for himself—in fact he was certain that Mr. Eccles was only waiting for him to sit down before he would spring to his feet and harangue us at length.

Thus challenged, Mr. Eccles spoke a few words in which he implored us to "Keep the home fires burning," or rather, not to let the old spirit of Guy's die out, and was very concerned that when he returned from India, and indeed when any old Guy's men should return to their Alma Mater, the customary barrel of beer in the Dressers' Room should be found in its old place.

Speeches then concluded and we all adjourned to the Smoking Room for an impromptu Concert, a fitting termination to a most jolly and satisfactory evening.

WE read with regret in the casualty lists the names of A. S. Liebson, A. C. Hancock, R. H. Lucas and H. P. Whitworth, all wounded. The last is now in the Guy's Officers' section, where we trust his recovery will be complete and speedy.

IT was intended with this issue to publish a photograph of the late Capt. A. Seabrooke, R.A.M.C., but unfortunately circumstances have caused an unavoidable postponement of the large plate. We reproduce, however, a small inset on a later page.

WITH the changes in the Residents at the end of last month, Messrs. J. F. H. Stallman, R. Curle, C. W. W. Baxter, and A. L. Punch have left us, while the new Residents are Messrs. I. R. R. Brogden, E. S. Phillips, R. Quesada, P. G. McEvedy and A. H. Taymour. Mr. F. A. Knott (President) and Mr. A. D. Marston (Vice-President) have been elected.

THERE is a welcome and becoming tinge of bronze on many a dresser's or ward clerk's face in these day's of sunshine, and we feel that the O.T.C. camp of a short while ago, though nowadays a compulsory affair, must have been a most enjoyable as well as beneficial holiday.

THE darkness and the Zeppelin raids are again descending upon us and lending an occasional mild excitement to our evenings. The tense moments after the arrival of a *second warning* a few nights ago seemed like an awakening from everlasting sleep. The surgery, momentarily plunged into inky darkness, became an erie spot for meditation as to the whereabouts of the raiders and their missiles, but the advent of the R.A.M.C. fortunately prevented any permanent nervous disability from overtaking the lone guardian at the Front.

IT has been suggested that a monthly Smoking Concert should be held in the College

Smoking Room, and the idea is receiving additional support from the abundant musical talent now in residence, and it is hoped shortly to announce more detailed arrangements.

CAN it be that the increasing number of open-air sleepers in the Park have inside knowledge as to the state of the hospital ceilings? Probably the prospect of an unhindered bomb is not so alarming as a few hundredweight of plaster which, we hear, someone escaped by the narrowest margin.

WITH anxious faces did the Residents watch a serious fire in the A.B.Co.'s car as it carefully conveyed the day's rations to the College back entrance, and great was the relief when the timely arrival of the Brigade, in great force, removed the danger to our provisions and peace.

Letters from Guy's Men on Active Service.

35th H.A.G.,
B.E.F.,
July 25th, 1916.

DEAR SIR,—I should like to give you a few particulars, as far as I know them, of my old friend Capt. Douglas Wilberforce Smith, R.A.M.C., who was killed in the recent offensive, during the attack upon Fricourt. He was born on August 1st, 1877, and was the son of a London physician, who practised near Oxford Street. He entered Edinburgh University in 1894, and after an illness which delayed his studies for some months, joined Guy's as a third year's man in October, 1898. He and I were surgical ward clerks at the same time, but on different firms. He took the Conjoint Diplomas early in 1901, and at later dates the M.B. Lond. and F.R.C.S. Eng. He was assistant H.-S. at Guy's in 1901, and on February 13th, 1902, he and I sailed to South Africa together as civil surgeons. He came home some time in October, 1902, and later went to South Africa again and practised in Mossel Bay for about six years; during that time he came home and was married to Miss Cockshut (I am not sure of the spelling), daughter of a well-known wall-paper manufacturer and collector of old china. Upon his return he finally practised at Pinner, Middlesex, and later in the West-end. He was for some time registrar at the Samaritan Free Hospital, having studied midwifery and gynæcology in Germany.

He was gazetted Temporary Lieutenant in the R.A.M.C. quite early in the war, I think in August, 1914, and was for some months in Hampshire, I think at Netley, where he did a lot of operative work—his wife could supply you with details of his service after that date—at the time of his death he was attached to the 6th Manchester's, curiously enough the same battalion which we accompanied to South Africa.

Before I conclude this sketchy account of his career, I should like to say that he was a very hard worker, and extremely keen to make his way in his profession: he never spared himself, and his surgical attainments were considerable. At the same time he was fond of sport, and when at Guy's used to play Rugby football for the junior team, and lawn tennis, a game which he kept up in later years. He was a thorough Christian, and whilst practising Christianity himself, he did his level best to impart it to others; after his return from South Africa he frequently, if not regularly, gave up his Sunday afternoons to take a Sunday School Class, and I honour him for it. He was intensely patriotic and offered his services very soon after war broke out, and was dissatisfied because he was not sent to the Front immediately; knowing him well as I did, I have not the slightest doubt that he upheld the honour of Guy's and his country nobly in the field of battle, and that in meeting his death he sacrificed his life in an endeavour to do his utmost for the wounded around him. He was a Guy's man and a gentleman, he worked hard and played hard, and died in his country's cause; what better epitaph could he have?

You have liberty to use these notes for the GAZETTE, if you like, Mrs. Smith could fill in the gaps.—Yours truly,
R. P. MARSHALL.

Chapel Notes.

A meeting of the Chapel Committee was held on July 23rd to consider arrangements for holding services during the cleaning of the Chapel. The House Committee have granted the use of the Court Room. The Chapel will be closed from August 14th until after Sunday, September 3rd. The Services in the Court Room will be as usual, except that Evensong will not be said on Sundays, August 20th and 27th, and September 3rd.

The possible improvement of the Sanctuary was also discussed. Messrs. Pocock, of Whitefriars, advised that nothing could be done until a new altar, corresponding in length with the reredos, was obtained. There are no funds for this at present.

The order was given for the last of the eight Panels, which is to be placed next to the Vestry. Owing to the war it will cost £60 instead of £50 which has been the price of the others. The subject is the Angel of the Ascension and we may expect to have it in place in a few months.

The Royal Sanitary Institute.

EXAMINATION FOR MATERNITY AND CHILD WELFARE WORKERS.

THE Local Government Board and the Board of Education have recently issued Memoranda on Infant Welfare Work, and at the present time, when there is particular importance attached to the rearing of a healthy population, a great deal of attention is being devoted to the various methods and agencies by which this may be ensured.

For the effective carrying out and administration of the measures designed, there is a need for workers well trained and with a high standard of qualification. In order to assist Local Authorities in the selection of suitable workers, The Royal Sanitary Institute have established an Examination in sequence with the present standard Examination for Health Visitors and for Inspectors of Nuisances, but requiring a wider experience and a more developed knowledge of the subjects pertaining to child welfare, including ante-natal conditions, and the laws and regulations relating to, and the organisation necessary for, such work.

The Examination will be supplemental to the Health Visitors Examination, the certificate for which is one of the qualifications named in the General Order of the Local Government Board (1909) relating to the office of Health Visitor and School Nurse.

The first Examination will be held in London on December 8th and 9th, 1916.

SYLLABUS.

Candidates will be expected to show a high standard of knowledge and a wide experience in all subjects relating to Child Welfare and Home Management, particularly those stated below.

Ante-Natal work and after-care of the Mother and Infant.

Hygiene of Infancy and Childhood. Children's ailments.

Principles of Infant Feeding. Infants' foods. Dietaries.

Home visiting, and the advice that the Infant Welfare Worker should be qualified to give.

Domestic economics.

Organisation and management of Infant Welfare Centres.

A general knowledge of the Agencies and Institutions dealing with Child Welfare and relief.

Duties of Superintendent of Midwives.

Acts and Regulations relating to Infant care and the protection of children, and Official Regulations and Memoranda having reference to Maternity and Child Welfare Centres, and duties of Health Visitors and other Workers. The Midwives Act, and Rules of the C.M.B.

A thorough knowledge of the Sanitation of the Home and its surroundings will also be required.

DETAILED NOTES ON SOME OF THE ITEMS INCLUDED UNDER THE HEADINGS IN THE SYLLABUS.

Pregnancy.—General treatment of pregnant mothers—rest, exercise, food—management of the breasts—danger signals, what they indicate—what to do when they are noted. Abortion, miscarriage, premature birth, their causes and prevention. Simple tests of the urine for albumen. Preparation for the confinement. Premature infants—methods of using incubators—still-born infants—methods of examining—causes of still birth—prevention.

Management and Care of the Mother during Puerperium.—Accidents and diseases associated with the Puerperium.

Care of Infants and Children.—Clothing—regulation of habits—growth—rest—exercise—education—diseases special to infants and their more obvious signs and symptoms, particularly rickets, tuberculosis, diarrhœa, constipation, infectious diseases, malnutrition, marasmus and infections of the skin.

Epidemic Diarrhœa.—Seasons—causes—prevention.

Weights of Infants and Children.—Methods of weighing—precautions to ensure accuracy—test feeds and their value.

Lactation.—Structure of the breast—physiology of secretion—composition of human milk—causes which affect the composition and quality of the milk. Common causes of insufficient milk and their treatment. Diseases of lactation—methods of preventing premature weaning. Breast feeding, its value to the infant—management of breast feeding—the best time for weaning and methods.

Artificial Feeding.—Why necessary—feeding bottles—cows' milk—tubercle-free milk—production of clean milk—simple methods of testing milk—how to obtain services of public analyst—sterilisation and pasteurisation of milk—peptonising—humanising—varieties of artificial food—their chief characteristics—preparation and cooking of special foods—indications for their use or discontinuance.

Maternity and Infant Welfare Centres.—Official regulations and reports—organisation and management—methods of recording—forms—charts—exhibits.

The Midwives Act.—Rules of the Central Midwives Board. The Children Act—Parts 1, 2, and 5.

Statistics of Infant and Maternal Mortality.

REGULATIONS.

1. Candidates must have obtained a Certificate as Health Visitor or as Inspector of Nuisances granted by The Royal Sanitary Institute, or some other body recognised by the Committee, at least six months before entering for this Examination. If evidence of special qualifications is given, the Committee may shorten this interval.

2. Candidates must also have the following qualifications:—

(*a*) The C. M. B. or other Midwives Certificate approved by the Committee;

(*b*) Have had six months' training in a Hospital for Children or in the Children's Ward of a General Hospital;

or six months' training in an approved Maternity Centre; or have held office under a Local Authority for a period of not less than one year as a Health Visitor or as Sanitary Inspector.

3. Application for Examination must be made on the proper form, and be sent to the office of the Institute 14 days before the date of the Examination at which the Candidate wishes to attend.

4. The fee for the Examination in Great Britain and Ireland is £3 3s. It should be sent with the application form, or 10s. 6d. on making application, and the remainder at least one week before the day of Examination.

5. The Examination occupies a portion of two days. On the first day it consists of two written papers, two hours being allowed for each. On the second day the Examination is *vivâ voce*, with practical work and one or more questions to be answered in writing, if required.

6. A Certificate of Competency, bearing the seal of the Institute, is granted to each successful Candidate.

7. A Certificate is not granted to any Candidate under 24 years of age.

8. An unsuccessful candidate is allowed to present herself, at invervals of not less than three months, a second and third time for Examination within two years of her first application on payment of half fees; but in every case the Candidate must make application on the prescribed form previous to presenting herself for Examination.

9. A Candidate having passed this Examination is qualified for nomination as a Member of the Institute, and upon signing the prescribed form and being elected will be called upon to pay only the reduced subscription of £1 1s, annually.

Extract from "The Evelyn News."

Ode to the Chain Gang.

When occupied in shifting screens,
And other useful duties,
Remember that, tho' full of beans,
You're not exactly beauties.

Attired in roomy hose and kilt
(Which fits where'er it touches)
Your absence would be surely felt
When business comes in rushes.

At 5 a.m. you're on parade
All smartly at attention,
Seeing that all the beds are made
And things we need not mention.

When terror stalks through Evelyn Ward
And anxious coves are crying,
The Chain Gang works both long and hard
To keep the old flag flying.

"Black Jack" is taking his revenge
And pains that sorely vex us,
Causing the patients all to cringe
And rub their Solar Plexus.

But with your noble aid, my boys,
Our troubles vanish like our dreams,
And when you march, oh dear, what joys
To see your banners are your screens.

The Head Nurse, generous loving soul,
Appreciates your heavy toil,
And nightly hands you each a bowl
Of bubbly, sparkling castor oil.

Correspondence.

To the Editor of Guy's Hospital Gazette.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

Chicken-Pox as an aid to the Diagnosis of Shingles.

Dear Sir,—I have lately had two cases which are rather instructive from a diagnostic point of view which may perhaps be my excuse, if one be needed, for again alluding to a subject which has already been ventilated in your columns.

No. 1 is the case of a mother who was puzzled to know where her boy (aged 10 years) had caught his chicken-pox, as she had been so particularly careful that he should go nowhere where there was a chance of infection. It was only after careful investigation that we were able to fix the blame on a painful patch which the mother had had about three weeks earlier on the right side of the throat. She had treated it with an ointment given her two years before for a patch of eczema on her arm, and when I was called in to see the throat all signs of vesicles had been obliterated by the use of the ointment. The intense pain, however, made me think of shingles at the time, although I did not feel certain about the diagnosis until the source of the son's eruption came in question. The interval between the two eruptions was twenty-one days—the usual period of incubation between the two diseases.

No. 2 was the case of a friend whom I met one day with his arm in a sling. I was not his usual medical attendant, but he informed me that he had had a severe attack of neuritis.

On questioning him he confessed that there had been a rash as well extending from the right wrist to the shoulder, also that the pain had started three days before the rash appeared. I told him that he had undoubtedly had an attack of shingles, and prophesied that his children would probably get chicken-pox; he then informed me that they had already had it, the rash broke out on the eldest boy exactly 14 days after the vesicles had appeared on the father's arm, and the second boy was attacked exactly 14 days after his brother's rash appeared. During the same week their two native "boys" were attacked, thus reversing the usual order of things in Rhodesia, were infectious diseases amongst Europeans are very commonly traceable to the native house-boy, who is apt to bring it from his kraal or native compound after a visit to his friends and relations.

Had it not been for the knowledge that we now possess of the connection between shingles and chicken-pox, the mother in the first instance might still be referring to her patch of "eczema," and the father, in case No. 2, to his "neuritis."—Yours, etc.,

Bulawayo, Rhodesia, W. P. LeFEUVRE.

Medical Science as She be Wrote!

As a poor provincial I may be pardoned for my ignorance, but it is hoped that sympathy may be extended to one struggling to keep pace with the immense advances of cardiac science that have been made during the last few years. I have lately been reading a very nice book on electro-cardiography, or E.C.Gy., for short; in fact, it is nice because it is short, otherwise my poor brain would not have held out.

It is a great thing to be authoritative, but when this is combined with assertiveness one feels we are having some. On page v. of the preface we are told that E.C.Gy. is the last Court of Appeal, and its judgement is rarely at fault; in fact, a very respectable House of Lords, look you! The Divorce Court isn't in it. Of course, we are impressed on page 16 that the full explanation of individual deflections in E.C.Gy. is a very difficult matter. Of course it is, or else it would be easily settled before it got to the Court of Appeal by a very puisne judge or medical student, but don't forget that on page 14 it is said there would be little gain in discussing the cause of the individual deflections of the E.C.Gy.

Now on page 17 we read "that in the physiological ventricular complex, the presence of a Q.R.S. group of rapid deflections followed by a slow blunt T deflection is an indication that the ventricular contraction has been propagated from fixed points. . . . . Curiously enough the E.C.Gy. in most of the lower orders is of a similar form, but there are no fixed points."

How can we mind our P.'s and Q.'s if we haven't got any? These fixed points, however, are not the only things that cannot be found, for on page 24 it is said that "evidently there are causes of hypertrophy with which we are unacquainted," and two lines further on, *mirabile dictu,* this Court of Appeal has a full sense that our conclusions may need subsequent revision.

After a little rest I opened this nice little book on page 76 and felt at last that we were getting there, for is it not written that "E.C.Gy.'s are often puzzling," whereupon I was reminded, as dear old Pepys would say, of that charming piece of poetry I picked up in my pinafore days—

Addition is vexation,
Subtraction is as bad;
Multiplication makes me crazy,
And division drives me mad.

But E.C.Gy.'s are not only puzzling, but even "actually misleading," "and always require careful analysis." Of course, I think it only right to emphasise that during my perusal of this nice little book I never for a moment forgot it was a book on medical science, for how could I, when in the middle of a proof I saw the words, "Now this is not inconsistent." Whoever expected to see inconsistency outside of "Alice in Wonderland," unless it be Alice in an electro-cardiogram?

"How doth the busy cardiogram
Go buzzing round and round?
To see if anyone in Harley Street
Is hard up for a pound."

Then, having had enough on page 76, I turned back to page 27 where "it is probable that these apparent inconsistencies . . . demand a closer investigation. ." "Naturally," one feels inclined to say, but is it polite? for on page 33 we are told that "the form of curves . . . are known approximately," whereupon one feels inclined to make a ! or—. Only on page 47 the slowing of my heart as the result of my "high vagal tone" makes me hesitate, for if there is one thing I pride myself on it is my tone, to say nothing of my vagus.

Fortunately we are not all affected similarly, since I find on page 55 that "premature ventricular contractions in different subjects give rise to curves of very different forms," so there you are, or, if not, where are you? "For usually the directions of Lead I. are reversed, but not invariably," which is something to be thankful for.

It does not do to be too particular, for "the distinction between flutter and . . . tachycardia may ultimately prove too arbitrary," with which I quite agree, for I am not certain what I am doing at this present moment, fluttering or tachycarding, since on page 103 I am told "that E.C.Gy. has little to do with value lesions," although two pages further on I read "The E.C.Gy.'s of mitral stenosis are often so characteristic that the value lesions may be diagnosed from these curves alone." Now, isn't this useful? though how Mr. Lloyd George expects a poor panel doctor to trot round with an electro-cardiographic apparatus I do not know, unless it can be worked on similar lines to a barrel organ.

The concluding lines are worthy of the Apostle Paul, for if there is one flesh of hearts and another of fishes "there is one congenital defect in which the curves should be normal," and after a large number of observations on one poor patient (pity his heart, as his mother used to say), "the curves are found to present no abnormality": isn't it wonderful?

This method of writing science is really very ingenious, and reminds one of Gilbert's young man who sang—

When I went to the bar as a very young man,
Said I to myself, said I.
I'll work on a new and original plan,
Said I to myself, said I.
When I got to the Court of Appeal,
"Young man," said I to myself, said I,
They've collared your new and original plan,
So you've missed to make good, said I.

Wounds of the Knee-Joint.

CLINICAL LECTURE BY MR. E. C. HUGHES.

Gentlemen,—I have chosen wounds of the knee-joint as my subject this afternoon, as it is a common injury in civil practice, and very common in war; and they are frequently most difficult, anxious and tedious cases to deal with.

In civil life these injuries can be grouped in three classes—

1. A punctured wound, of soft parts only, from kneeling on a sharp object—*e.g.*, a needle.

2. A punctured wound involving some damage to the bone; and

3. As part of a laceration of the limb from accidents, such as being run over by a motor-bus, etc., where the opening into the knee-joint is only a part of the injury. This class I do not propose to deal with.

In war injuries two groups can be made, according as the bones are damaged or intact.

Anatomy.—Let me remind you of the extent of this joint and a few other anatomical points. The synovial membrane is the largest in the body; it reaches down to, but no further than, the upper border of the tibia Laterally it extends well backwards upon each femoral condyle, while above it extends for about two fingers' breadths above the upper border of the patella under the quadriceps tendon. This extension usually communicates with a larger bursa lying just above and under the crureus muscle.

A. *Perforating wounds of the joint without injury to the bones.*—In civil practice, penetration of the knee-joint from kneeling on a needle or other sharp body is easily recognised; there is the initial pain due to the wound of the skin over the joint; removal of the needle by the patient, if it has not disappeared, may be followed by the escape of a few drops of clear oily fluid, synovial fluid; walking may be immediately painful, or the pain may be delayed for a few hours, when the joint becomes obviously distended with fluid, the movements become increasingly limited. and the joint takes up a position of slight flexion. There is a certain amount of pyrexia, which may be considerable if the joint is acutely distended, and if organisms were introduced at the original injury, even though they may not be of high virulence. As the result of the injury a traumatic arthritis has developed.

Most of these cases require no further treatment than rest on a straight posterior splint with the knee in full extension. This will soon be followed by loss of pain and more gradual absorption of fluid. Removal of the foreign body, when retained, may be necessary, if the symptoms recur on exercising the joint, for the foreign body may be protruding in part into the joint, and may damage the adjacent synovial membrane when the joint is moved. We must distinguish between recurrence of the symptoms and the occurrence of a painless synovitis on movement. This latter depends on the loss of tension of the capsule, dependent on the wasting of the quadriceps, which follows any immobilisation of the knee, and is likely to persist so long as the wasting is present

Some cases, however, present more severe symptoms, the pyrexia and pain are more severe, and the patient cannot bear to have the joint moved through the smallest range. It may be suspected that pus is present in the joint, a point which can be at once decided by drawing off some joint fluid through a large aspirating needle.

In many cases the synovial fluid may be only turbid and blood-stained, and the removal of the fluid by aspiration, followed by pressure over the joint, may result in alleviation of the symptoms and the recovery of the joint.

We must not be in too great a hurry to wash out the joint through an incision, and to drain it, unless actual pus is present and destruction of the cartilages is taking place. If an acute suppurative arthritis does follow such a punctured wound of the joint, which is excessively uncommon, the joint can be washed out and continuously irrigated with normal salt solution, through a tube in one incision in the suprapatellar pouch, and one far back over each condyle in the lateral extension of the

joint. We must avoid gauze drains, which act as plugs and not as escape channels, and which promote adhesions between opposing surfaces of the synovial membrane. These adhesions may cause the greatest difficulty in establishing joint movements again. The tubes must be removed as soon as possible.

A perforating wound of the joint by a bullet which has passed through without damaging the bone causes an out-pouring of blood into the joint, *i.e.*, a hæmarthrosis, and, as a rule, expectant treatment on a back splint is all that is required as soon as the joint becomes less tense; the absorption of the blood, and the recovery of the quadriceps may be hastened by massage.

In these bullet wounds, sepsis, resulting in an acute septic arthritis from the carrying in of foreign material and organisms, might be expected to be of common occurrence, but as a matter of experience it is not so.

B. *Perforating wounds of the joint with injury of the bones.*—These occasionally occur in civil practice. I had one case where a man fell on to a meat hook, perforated his joint, as shown by the escape of oily synovia, and fixed the point into his external condyle slightly comminuting its external surface; the joint at once became swollen, painful and fixed. I explored the wound at once, washed out the joint, and left a tube reaching to the joint, and a gauze drain down to the injured bone. In this case, as in all the cases complicated by bony injury, recovery was slow, the patient not being discharged until four weeks later, and was even then using crutches. During the treatment of these cases, so long as the wounds are unhealed, the joint must be kept at rest in an extended position.

The most anxious cases are those in which a bullet or a piece of shell has damaged one of the bones, and the wound has become septic. I have several of these cases, and those in which the tibia and femur are damaged are far more serious than in the case of the patella, which, being a small and superficial bone, is easily dealt with. One soldier had his patella smashed and the joint opened; this was treated in France, the bone being cleansed and the skin wound partly closed.

When I saw him a few days later his joint was somewhat flexed, acutely distended, but not painful on manipulation, and movements of the joints were painless through a small range. His temperature remained high, 103° F., for three or four days, and on exploring the wound under an anæsthetic, the joint was found to be full of pus; some necrotic fragments of the patella were removed, and tubes were inserted for the frequent irrigation of the joint. The temperature came down at once, and the joint was soon under control.

A far more serious case I saw with Dr. Scott of the Southend Royal Naval Hospital, where as the result of a perforating wound of the upper extremity of the tibia, suppurative arthritis of the knee-joint, developed, with a severe toxæmia; absorption of the articular cartilages was evidenced by the extreme pain experienced on even shaking the bed, and by the starting pains which would suddenly arouse the patient with a shriek. Dr. Scott opened the joint freely, irrigated and drained, and after an anxious time, during which many collections of pus in the leg occurred, the patient is well on his way to recovery, but after many weeks.

Other serious cases with which I am still struggling are septic wounds of the condyles of the femur, involving the knee-joint; in one case the external condyle was comminuted and turbid synovia was escaping through a postero-external wound. Under an anæsthetic bits of khaki and splintered bone were removed, but the communication with the joint could not be found. For many weeks collections of pus developed, but fortunately the knee-joint still appears to be intact, though the subcrural bursa became distended with pus. In this case either the bursa did not communicate with the joint or the inflammation had fortunately blocked a small communication between the two.

Another similar case I have twice operated on; on the first occasion only finding by an exploring syringe turbid fluid, I explored the external condylar wound to find it perforated

and lodging a bullet. On the second occasion, a week later, the joint contained pus, and tubes were inserted for continuous irrigation.

I believe the correct treatment for these septic wounds to be as follows: aspirate the joint and note nature of fluid; if turbid or blood-stained, leave the joint alone. Explore the bony injury, having skiagrams in two different planes by your side; if the anatomy of the part allows it, explore through the enlarged original wound, if not, through a suitable incision, and lay well open the infected and damaged bones, removing the foreign body, and insert a drainage tube.

In many cases it will not be sufficient to explore the bony injury without removing bone to allow of efficient drainage. Continuous irrigation of the joint, while leaving a septic focus in the bone and adjacent to the joint, will not benefit the patient. It must be a thorough laying open of the infected damaged bone together with continuous irrigation and free drainage.

Some surgeons treat these injuries by dividing the patella and for a time packing the joint with gauze and leaving it in a flexed position. Then, on the subsidence of symptoms, the joint is put up in the extended position.

This treatment I do not believe to be necessary or correct, unless the infected bone is dealt with at the same time, and the treatment then becomes heroic.

A more surgical procedure is a set excision of the joint, which removes the ends of the bones, but, as a rule, removes a great deal more than is necessary. Finally, it may be necessary to amputate.

Change of Address.

A. J. K. Drew, Bolingbroke Hospital, Wandsworth Common, S.W.

C. R. Hodgson, M.D., B.S Lond., "Egmont," Wolseley Road, Point Piper, Sydney.

Albert Reeves, Herbert Hospital, Woolwich.

Capt. H. G. Dresing, R.A.M.C., from 3rd Bridging Train, R.E., to M.O. in charge, 3rd Pontoon Park, R E., B.E.F.

Captain A. Seabrooke, R.A.M.C.
Died in Mesopotamia, July 1st, 1916.

The Treatment of Hæmorrhoids by Interstitial Injection.

By T. BIRD, M.R.C.S., M.A. Oxon.

[With acknowledgments to *The Lancet.*]

Although this treatment has a history of many years, I do not think it has received the attention that its success deserves. It first came to my notice some eight or ten years ago through my old student friend and colleague, the late Sir James Goodhart. Later, requiring some relief from hæmorrhoidal annoyance which was becoming a constant irritation, I chose this treatment for the following reasons: The prospect of complete relief in eight or nine visits, each taking a quarter of an hour; very slight pain of no duration; and at the same time no interference with my ordinary life and work. The only change that I noticed in the parts treated was an appreciable, but very slight, warmth. It is now some years ago, and I am still perfectly comfortable.

I should like to state that this article was written prior to the appearance in the *Lancet* of the articles on the same subject by Mr. Arthur S. Morley* and Mr. S. Swinford Edwards.† I have thought it better to leave it as written, for in matters of detail there must necessarily enter the personal equation.

Some critics have suggested that there is a likelihood of return. This has not occurred in my own case or work, but if a part of the pile be left untreated it is likely to increase, and I think this must

**Lancet*, March 18th, 1916.
†*Lancet*, April 15th, 1916.

have given rise to the idea of recurrence. There can be no return in the part destroyed, and in this opinion I am confirmed by Mr. Dudley D'A. Wright, who kindly operated upon me, and whose brochure on the subject anyone who means to take up the work should certainly procure.

Pure carbolic acid as an injection into pile tissue was first used about half a century ago in the United States of America, but through misuse the practice fell into abeyance. Some 30 years ago it was resumed in a mitigated form by Dr. Hoyt, of New York. The deviations from his treatment in many hands seem to have caused disappointment, perhaps through seeking more rapid or more complete success.

Sir James Goodhart‡ speaks very strongly on the operations in vogue, and as I can confirm his remarks, both by my own practice and that of over 50 years of anæsthetic work with first-class surgeons, I cannot do better than quote him, with the remark that the forecast held out by the surgeon is not always realised by the patient:—

"Now, why should I, thus out of order, put in a plea for the more frequent use of injection? I do so because I happen to have seen a good deal of the partial and poor successes of the common operations, whereas the results of injection have seemed to me to be uniformly good.

"Some years ago I became very dissatisfied with the results of ligature. More recently I have known of poor results by the Whitehead operation as well—first, because the patient was laid up for several weeks; secondly, because the shock of the operation may be very detrimental; thirdly, because even within my own small experience I have known of cases of serious local trouble afterwards invaliding the patient for a long time; fourthly, I have many times found a definite membranous stricture at the anus where an operation has been performed; and, lastly, so many have told me that there has remained, more or less permanently after operation, a state of discomfort in one way or another that was by no means pleasant."

Patients unfortunately do not seek relief until an acute "attack of piles" occurs. This it is as well to palliate in the ordinary way until the inflammation or strangulation is relieved, otherwise the treatment may be painful. The best time for treatment is while the piles are giving no trouble. An acutely inflamed external or strangulated pile may with relief be emptied of blood and then have three or four piqûres; when introduced the solution stops the bleeding and often relieves the pain immediately.

Hoyt's treatment requires no private home or hospital for a fortnight or three weeks, no anæsthetic, no keeping to bed, no nurse, and no subsequent pain. There is no stretching of the sphincter. It is better to avoid spirits, highly seasoned dishes, salt, and coffee; otherwise life may go on as usual. In many cases relief is almost immediate. One patient of mine, a clergyman, whose life was a misery, said on the third day, after the first piqûre, "I have not had such a two days for six years." Subsequently in a note he thanked me for his "new life." Riding men, rowing men (I have seen all the seats in a college eight stained with blood), men from the trenches, and drinkers of Gallipoli water seem to be the chief sufferers amongst otherwise healthy men.

It is 50 years ago since I first had a hard external pile when captain and stroke of my college eight. I did not want to leave the boat, and wrote to Mr. James Long, professor of surgery at Liverpool, to whom I was still indentured, asking what I could do under the circumstances. The reply was worthy of a pupil of Abernethy: "Row on it until it bursts." I did, and I hope my crew never noticed the first ten minutes' rowing each day, until the parts got warm. The acutely expected event came off, and we made four bumps.

The solution recommended and used by Hoyt consists of equal parts of hazeline and distilled water, to which is added 10 per cent. of pure carbolic acid; the whole of the acid is not dissolved unless warmed; the bottle must be shaken when the solution becomes turbid from the finely disseminated acid, and is then ready for use. It should not be allowed to run on mucous membrane or skin, as in both cases it gives rise to soreness. I have had no trouble through carbolic acid absorption, though I have injected as much as 15 minims at one sitting.

It is not only for hæmorrhoids that the treatment is useful (in my own case there was a polypus in addition to three hæmorrhoids), but also in cases of prolapsus ani. I can look back upon some cases in old people that were treated by astringents which I should now treat in this way rather than with cautery or by incision—the uncomfortable alternatives.

What are the disadvantages of the treatment? There are certainly two: the number of visits, and the passage of the anal speculum. The speculum I have found to be best has been Kelly's sphincteroscope, both for the first examination and the ensuing treatment, but it should always be well warmed before insertion and well lubricated either with vaseline or lubifax, which is more easily washed off than vaseline.

The Holborn Surgical Instrument Company have made me a self-retaining speculum, as Kelly's requires one hand to retain it during the injection by the other. Another has the window shaped to prevent the mucous membrane in front interfering with the view of the hæmorrhoid.

‡*Practitioner*, December, 1914.

It is better not to inject a pile near the junction of the mucous membrane and the skin or external to that line before the inner or upper portions have been treated.

External piles (inflamed) should be allowed to subside under appropriate treatment before injection, and the patient should be advised against taking wine and spirits and highly seasoned dishes and should be given medicine to produce soft evacuations. A platino-iridium needle, not too fine and about an inch and a quarter long, is, perhaps, the best, though I use a short, stiff needle on a prolongation that fits on to the "Record" syringe, as this gives a clear view of the length of the speculum. Care should be taken to keep the needle in the long axis of the bowel and a slight side-to-side motion as the plunger is pressed on tears the interior of the pile, and if the needle is kept in for a few seconds there is seldom any bleeding. After an injection or two the pile surface becomes hard, so that future injections should be made between the old scars until the pile is completely treated. An ordinary pile condition requires eight or ten piqûres; a commencing pile only one or two. A soft, freshly-formed hæmorrhoid may be injected with from six to ten minims; these are ones that bleed most, but there is no occasion to apply any styptic, the carbolic acid and the hazeline being sufficient to control bleeding. At the first visit I now give preference to injections of not more than three minims superficially to different parts of the surface of the pile; this makes subsequent injections almost painless, and prevents the swelling caused by larger injections made more deeply.

It should be remembered that the expediency of the treatment is that it should cause no inconvenience beyond the number of visits to the operator. I like to operate with only two days between, having found that cases so treated do better than do those with long intervals and larger injections. I have myself taken a run in less than five minutes after a piqûre, and Mr. Charles Higgens, my colleague at Guy's Hospital, tells me that he played squash rackets on the same day that I had operated and had hunted on the next.

In exceptional cases I have injected external piles (inflamed), but this is a painful operation, and it is best to treat as above, or at least to empty them of blood first and return them if possible after injection.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

A Landsman with the Fleet.

I.—FIRST IMPRESSIONS.

An odour like that of innumerable bottles of Schweppe's soda-water, the patter of heavy rain and the low murmur of a sluggish flood, these and the universal *greyness*. Later, when the eye began to take in details, one counted the long black forms of destroyers, the even more disproportionate cruisers with their stubby masts and silhouetted guns, the squat depôt ships surrounded by fussing small craft, the incessant traffic of pinnaces and picket boats; but the first crystallization is a monotone. As one approaches, the unnatural calm becomes apparent, and soon, too, its explanation. The whole surface of the water is covered with a shimmering opalescence, which comes and goes in noisome floods of rainbow colourings. It is oil, and strong indeed must be the wind that can do more than ruffle it. No fish can live there, for the depths below are airless, and the sea-fowl deprived of their natural food, struggle fiercely for the ships' offal cast astern. There is little here of beauty, nothing save, perhaps, a sense of vast potentialities redeems the scene from utter desolation. As the dusk falls, lights shine eerily through the mist, blinking from ship to ship, till sometimes the whole basin is covered with twinkling starpoints. What do they mean? Who extricate the seemingly inextricable? Is it to order Flotilla — to proceed to —, or merely an acrimonious passage of arms relative to the alleged mustiness of water supplied to H.M.S. —, or perhaps an invitation to go "poodle-faking."* Who knows? I don't! Then, as your boat chugs alongside amid the piping of whistles and the rattle of boathooks, you clamber precariously up the ladder hanging from the quarter-deck, salute, and proceed to inspect your new home. It seems at first a welter of mechanisms; wire hawsers, guns, torpedo tubes, shells, mines, bombs, a *multum in parvo* of efficient destruction. The decks are strewn with four-inch shells, passage anywhere is at the risk of life and limb. Everywhere the hand lies ready on the releasing apparatus of some infernal weapon. For a while the complication appears so absolute, that one can barely appreciate the possibility of action. It is only later that the marvel of instant readiness dawns. The whole ship reverberates like a hollow shell. The decks give out a sound like the stones covering a vault. The slowest motion of the engines shakes the ship from end to end. The slightest helm sets the movable gear chattering in uproarious medley. Lying here at anchor, grimy, some black, some grey, some vermillion, others striped, zebra-like, in the throes of repainting, they seem like the puny, ill-formed offspring of those vast grey cruisers, that

* Thus, in naval parlance, the joys of social intercourse.

stand majestic, surrounded by smaller craft, as a cathedral dwarfs the lesser dwellings around it. We destroyers are, if you will, their handmaids, escorting them in and out, following slowly in their wake, rushing, with turbines purring, to deploy on their flank, moving always attentive to the unseen deity at whose command those busy little flags move up and down from the signal platform. Seen, as I said, in harbour, they have little beauty, these "eyes of the fleet." Their function is dynamic, and in repose their lines have none of that strange grace which motion calls to life. See them, as I see them at this instant, moving like long grey serpents in easy gliding movement, their bows picked out by a long plume of foam, in their wake a line of colour running the gamut from ivory to ultramarine, and you will not deny their loveliness. Or again at night, as sinister silhouettes against the long northern twilight, a bank of lead pierced with gold, bordering a sky of palest green, engaged on heaven knows what mission, sailing as by instinct without lights, without apparent guidance save the rare twinkling of the mover, and you will be moved to instant respect. But we must complete our examination of the ship which is to provide us for some months with a home.

Under a grey awning, called for some subtle reason a "funk hole," yawns a chasm, which when your eyes accustom themselves to the gloom, shows a ladder plunging steeply into the abyss. With clumsy, landlubber feet one puts forward a tentative foot, and following the agile lieutenant to whom these acrobatic exercises are second nature, disappears bodily through the main hatchway, which leads to the captain's "flat." In destroyer parlance a "flat" is the space between two bulkheads; thus astern of the captain's flat is the officers' flat, where the other officers live *vis-a-vis* in little boxes, like the animals in a dog fanciers. Yet further astern is the flat known as the captain's stove, where it is the fate of the surgeon probationer to spend a troglodytic existence surrounded by stearing gear and steam pipes, whilst for'ard of the captain's flat is the petty officers' flat, from whence the coxswain's banjo is wont to disturb the night's serenity with reminiscent sentimentalities. "This is the wardroom," says the lieutenant, and bumping one's shins against some obtrusive bit of furniture—it takes some time before you grow used to the limitations of movement imposed by the cramped surroundings—one gazes with a dreadful curiosity at this overcrowded rectangle where, if rumour be true, so much of one's time for the next year or so will be spent. It is, perhaps, worth while to describe it in detail. Picture a low-roofed, box-like chamber formed apparently of metal, and lit with a dim blue green light, such as you see in aquariums; a light which changes in waves of colour, reflecting now a little sunlight, now a ripple of gold waves upon the ceiling, now growing suddenly obscured as a wave dashes over the misty scuttles, or a great barge looms alongside to deliver cabbages or high explosive. It is a light which soon seems to grow an integral part of one's life, typifying a sort of tranquility, that almost monastic resignation to the strange forces around you which you control in part, but whose ultimate mission is beyond your ken, which makes the sea-going man such a strange blend of mystic and materialist, flying to the one because he fears the other, yet returning always because he is *afraid*. On the other side of the central door stand the bookcase and the sideboard, and for a moment the former gains our attention. Surely there never was a stranger collection of conflicting standards. Hustled by William Le Queux's revelations of German machinations, by Fred. M. White's brightest and best, and Hall Caine's great spiritual romances, stands a slim yellow volume: Renan's *Souvenirs de l'Enfance*, jostled by the Baroness Orczy is a delicate collection of essays by Arthur Symonds. One ponders awhile the strange contradiction, this daring blend of incongruities; it is a mystery that further knowledge alone can solve. The sideboard is a brown composite structure, built, as far as one can judge, of two chests of drawers, surmounted by an upperworks of glass racks and bottle stands. The original and legitimate fitting was, I discover, destroyed by a shell in the battle of ——, a combat for which we carry a proud commemorative bar. However, the present article serves its purpose admirably, beyond a tendency to excessive rattling in bad weather. Close alongside, and running more than half the total length of the wardroom is the table, a solid structure, now happily chained to the floor, a precaution considered necessary since a certain night at sea when it flew across the room and struck the chief engineer with marked vindictiveness in the abdomen. At present it looks tranquil enough, and only the "fiddles," a sort of domestic stormy petrel, remain to show that it has ever been anything but well conducted. Along either side, beneath the scuttles, run two well-worn horsehair settees, where, one is told, any supernumary officers are expected to sleep, though sleep and those settees seem incompatibles. A little to the left, in the only free space available, is a slow combustion stove, a couple of battered armchairs, and on a little pedestal the ship's gramaphone, and an assortment of illustrated papers mostly a month old. The roof is a bewildering mass of pipes, cranks, ventilators, port-holes, wires, and speaking tubes; in the floor are two huge hatches which come between us and I know not how many pounds of cordite. At first the notion is apt to be vaguely alarming, but after a while one takes the chances of being blown sky high with the greatest unconcern. For the first few days, at all events, this is all one sees. For'ard, beneath the bridge and the chart house, are the men's quarters, abaft those great squat funnels the stokers and engine room artificers ply their trade, somewhere the wireless operator sits

listening; unobtrusively a watching eye notes every flash and flag hoist. But for a time, at all events, these and a hundred kindred activities must remain mysterious, as mysterious, shall we say, as the great unknown in Whitehall which controls all our destinies.

G. H. F. G.

Should a Christian Fight?

By B. JONES, M.D.

As there appears to be a considerable number of conscientious objectors, I have made an endeavour to get at the real teaching of the Scriptures as to war and soldiering, in the hope that the remarks may prove useful. The objections seem to be grouped under three heards: (1) Our Lord's Own Example; (2) The Sermon on the Mount; (3) The General Unlawfulness of War.

(1) Jesus Christ came into the world for one definite purpose, to be offered up as a sacrifice for sin. If He had resisted those who came to arrest and crucify Him, He would have been resisting God the Father's will, as He expressly states in Matt. xxvi. 53: My Father would send angels to rescue Me if I wished; but if He did, how could I be lifted up? It was impossible. He must of necessity be mocked, scourged, and crucified. Therefore, He forbids His disciples to use the sword on His behalf, and heals the servant of the high priest.

(2) *Though parts of the Sermon on the Mount* are of general application, the sermon was addressed to His disciples *only*, though probably others were standing by listening to His words. This is proved by His saying to them (Matt. v. 13), "Ye are the light of the world, the salt of the earth," etc. Also by His telling them that they are to rejoice when they suffer persecution for His sake, and compares them to the prophets of old who suffered in like manner. And so His commands to them to take neither purse nor scrip, nor to resist those who would rob them of their garments, is obviously addressed to them in this capacity, and for this time only, because later, in Luke xxii. 35, etc., He especially draws their attention to His former words, and tells them that now they must act differently and take a change of raiment, a purse, and also even *buy a sword*.

If any deny this explanation and say these commands are addressed to Christians everywhere, and at this time, then I would ask, "Are you prepared to lend to all who ask, to take your money out of the bank or building society, and *give* it to your neighbour or your next-of-kin who has met with misfortune? Are you prepared to give the clothes off your back to those who want them, to take no thought about your raiment, to be as well contented with an old dirty garment of out-of-date shape as with a clean and fashionable one? Does a dry crust and a drink of cold water meet your wishes as well as a cut from the joint and two vegetables, with a sweet and cheese to follow? Do you insure your house, your own life or that of your family, and do you save some of your income for a rainy day? Do you live in a house according to the size of your income, or are you content, like Paul, to suffer both hunger and thirst, and to have no certain dwelling place (1 Cor. iv. 11), not even a common lodging house? If you say this is going to extremes, then I say you must either take it or leave it, not take what you like and leave what you don't, and make Scripture a cloak for your cowardice. You can't pick and choose your texts of Scripture.

(3) The General Unlawfulness of War. War is a dreadful thing, not to be lightly undertaken by anyone, but not to be shirked by those who value honour, righteousness, and the well-being of others beyond their own personal ease and comfort, yea, even life. Soldiers are international police. If we use policemen to protect our property and persons at home, so must we, when necessary, use soldiers to protect our own liberties and life when threatened by a wicked enemy.

Samson, Jephthah, David, and many others were especially raised up and blessed by God to deliver the Israelites from their enemies, whilst those who kept back, as Ephraim, were cursed (Judges v. 23). It is quite true that God could defeat our enemies for us without our raising a hand in our own defence, the same as He could give us the fruits of the fields without our labour. That He does not do so, and never in the history of the world since the fall, has He done so, is surely evidence enough that He does not intend us to lie a-bed in the morning, to fold our hands in sleep, and expect everything to be done for us by an Almighty power. We might just as well leave our gardens without fences, our houses without doors, and our safes without locks, as neglect the ordinary means of defence against an enemy.

Why should we whip a naughty boy, or send a thief or murderer to prison or death, because we can do these things without danger to ourselves, and refuse to fight an enemy because there is some risk to our own life in doing so?

The Old Testament is not contrary to the New, and if any want New Testament teaching, let him read and consider that it was to a soldier that Peter declared the universality of the Gospel promise (Acts x.). Again, when Paul's life was threatened by conspirators, he was protected by horse and foot soldiers (Acts xxiii. 23). Further, when various persons came

to John the Baptist to ask what they should do (Luke iii. 14)—amongst them were soldiers—John did not say to them, "Leave your job and get a better one;" but "Do no violence to any man, and be content with your wages." The "no violence" here meaning, do not go beyond your orders. If the calling of a soldier were an unlawful one, we might have expected a very different answer. Indeed, I think it may be taken as a direct sanction to the vocation. Our Lord's own words, "Greater love hath no man than this, that a man lay down his life for his friends" (John xiii. 15). Can a man in these days show his love for his country in any better way than by losing his life (if need be) for her sake? If space permitted, I could amplify authority in favour of warfare in a legitimate and necessary cause.

There is one other action of our Lord which has some bearing on this question. When He cursed the barren fig-tree it withered at His word; but when He drove the cattle and the dealers from the temple (John ii. 15), He used a scourge which He applied probably either to the beasts or the persons who sold there, perhaps to both. At any rate physical force seems to have been used, and a weapon to effect what might have been done by miraculous agency. It is not for us to be wiser than our Redeemer. Just one more thought. Stealing is just as wicked when done wholesale as in detail, and murder is murder when done on the large scale as when done to single individuals. But to take the spoil from the robber, and to preserve the lives of others by shedding, if necessary, our own blood in their defence, is compatible with Christian charity of the highest degree. A war of defence is commendable, a war of aggression wicked and murderous. All rule, peace and prosperity would be destroyed both at home and abroad if everything were yielded up to him who used violence. The world would then be ruled, not by righteousness, but by brute force, and that way anarchy lies.

I think enough has been advanced to show that, whilst all our reliance, all our hopes must be placed in the Almighty power of God, we must at the same time admit that we must go forth to battle armed with such weapons as we have proved.

God always works by means, else why were we born?

Appointments.

Royal Army Medical Corps.

H. G. Dresing to be temporary Captain.
Albert Reeves, Commission of temporary Lieutenant.

Petrol Economy for Medical Men.

August 1st inaugurated the "ticket system" in England, in order to cope with the petrol shortage. No doubt motorists have decided with the usual stoical English philosophy, to "take things as they come." Some, however, have gone so far as to lay up their cars until the end of the war, or at least until things improve with regard to supplies of the precious spirit. The more ingenious or adaptable have tried one of the several substitutes now being marketed, with varying results, but the majority of these seem to have arrived at the same decision, namely, to use petrol in combination with paraffin-oil, used in the proportion of one-third paraffin to two-thirds petrol, or even half-and-half, but with this there is a certain lack of power, especially on hills, and also the serious trouble of carbonisation to be considered. The bad effects mentioned can, however, be avoided by the addition of a practically new product, which enables one to be not only patriotic by assisting in the economy of petrol, but at the same time thereby benefitting financially, owing to the saving effected. This is a fuel in tablet form which costs about one penny each and is sufficient to treat two gallons of spirit; and it only becomes effective when added to petrol, paraffin, or similar spirit, and is, therefore, quite safe, it being almost impossible to light same with a match, and it has only to be dropped into a two-gallon can to become operative. The product referred to was placed on the market about six months ago under the easily remembered name of "Spots," and is manufactured by one of the largest producers of benzole and makers of coal tar products in Great Britain—The Coal By-Products Company, of 112, High Holborn, W.C. This firm is aiming at the capture of trade hitherto secured by Germany, and this latest invention will certainly be a nail in that country's coffin.

The effect of "Spots" is to strengthen and empower petrol, and to build up weaker spirits, so that with the addition of a "pill" to a mixture of two gallons of paraffin-oil and petrol, as much, or even more power is obtained than from the best quality of petrol. When one compares the cost of paraffin with that of petrol in the proportion we mention, the great saving effected will be easily apparent even when the ½d. per gallon for "Spots" is added, and by so doing efficiency is increased.

When "Spots" were first introduced they were naturally viewed with a certain amount of scepticism, but when the technical press carried out exacting tests the results more than proved the makers claims. The "Motor Cycle" found during a test they made at Brooklands, that the increased mileage per gallon was 28% instead of only 25% claimed by the manufacturers, which fact speaks for itself.

Therefore, in supporting the efforts of the Coal By-Products Company every motorist is (1) assisting in the

capture of what was, until the outbreak of war, an essentially German speciality, the extract of by-products from coal. (2) Economy in the use of petrol. (3) Finally assisting the motoring community and themselves by keeping the cars on the road, which means the circulation of money, which is necessary for the country's trade, and at the same time doing something to break the power of the petrol ring which threatens to strangle the goose that lays the golden egg, *the poor English motorist*

Two Cases.

These two cases have been briefly described as being of possible interest in view of early diagnosis and treatment.

A. William T., æt 15, was admitted under Dr. Beddard to medical wards on June 11th, 1916, for acute pain in the right side of chest and abdomen, with vomiting. There had been no previous illness and patient was a generally healthy boy. A six days history of increasing pain with constipation and vomiting was given, and on admission there was marked rigidity on the right side of abdomen, general abdominal pain and tenderness but no vomiting after patient was in the ward. R.E. showed no abnormality beyond pain to the right, and the chest showed no signs beyond very slight impairment of note at right base behind. An acute abdominal condition was suspected and patient watched.

12th June, 1916.—Temperature remittent, 104° F—100° F, pulse practically constant at 100 and resp. 24–28. Pain showed some decrease after good result from en. sap., and rigidity appeared chiefly high up on right side. Nothing could be felt abdominally. A few fine rales heard at base of right lung, and it was decided to defer laparotomy.

14th June, 1916.—Patient's general condition had remained constant, but on aspiration 20 c.c. of clear straw-coloured fluid were aspirated from pleural cavity over right base. On cultivation this fluid gave a growth of staphylococcus longus. During this time pain became less and entirely centred below right costal margin behind and in front. Rigidity less, temp. lower.

18th June, 1916.—Patient's left leg had become painful and found to be swollen immediately below the knee-joint. Operation showed osteomyelitis of tibia and cultivation of the pus gave staphylococcus aureus only.

A day later pain appeared in left shoulder, followed by œdema and swelling, and on 23rd June, 1916, joint was aspirated. No pus was found, but synovial fluid gave pure growth of staphylococcus aureus.

For the next fourteen days a number of abscesses formed in rapid succession in shoulder region and in relation to ribs on both sides of chest. They were opened and drained, and on each occasion rapidly reached a state of only moderate discharge. The patient was then extremely wasted with an irregular pyrexia varying between 101° F. and 99° F., and pus on all occasions gave a pure growth of staphylococcus aureus.

July 11th, 1916.—Patient was given 25 mill. staphylococcus aureus autogenous vaccine and showed a slight reaction as indicated by increase of pain and temperature. Eight days later 50 mill. were injected with similar result.

July 23rd, 1916.—A cultivation taken from patient's teeth gave chiefly staphylococcus aureus, but also streptococcus longus, and a vaccine having been prepared on July 26th, patient received 75 mill. staph. aureus and 5 mill. strept. longus.

At this time the general condition of the patient was improving, and although extreme wasting had occurred there was only moderate pain. All old cavities and wounds were granulating well under ordinary dressings, and apart from the removal of a sequestrum, consisting of the whole of angle of the left scapula, there was no need for further surgical treatment. Vaccination has been continued, and patient after being for some weeks practically moribund is at present, though very emaciated, in a steadily improving condition.

B. Lily C., æt. 23. Admitted under Dr. Beddard on July 24th, 1916, with obscure abdominal symptoms, rigors and jaundice.

A history was given of admission to a Fever Hospital as (?) typhoid about three weeks previously, where she had several short attacks of abdominal pain and transient jaundice followed by diarrhœa. Temperature had been extremely irregular, but under general treatment condition improved, and with a definitely negative Widal reaction she was admitted to the medical wards.

On 24th July patient had no abdominal tenderness, and complained only of aching in epigastric region. Nothing could be felt abdominally or R.E. Temperature irregular, rising to 101° F.; history of recent jaundice, but this not seen. Heart and lungs appeared normal. Condition remained stationary for four days, during which time bowels were normal and patient was free from pain, and able to sit up and take full interest in surroundings.

July 29th, patient's temperature rose suddenly to 104°, and with only slight remissions remained at this point. Bowels constipated, and abdominal pain increased and general.

July 30th, slight rigidity and dullness to percussion on right side of abdomen. Tenderness not marked. A blood count showed definite polymorphonuclear leucocytosis, and on July 31st, the patient's general condition having become rapidly worse, laparotomy was decided upon.

The operation showed a gangrenous retrocæcal appendix firmly bound down and surrounded by an abscess

cavity. Removal of the appendix being found impossible the cavity was opened and freely drained. Patient never showed signs of recovering from the operation and died on August 2nd, 1916.

Post-mortem examination showed the following:—Large abscess cavity formation with adhesions and appearance indicating a course of probably at least ten days, and acute suppurative pylephlebitis with multiple abscesses in the liver.

F. A. K.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

The relief work done by British women in Serbia is described in "Through the Serbian Campaign," which Messrs. Hutchinson & Co. are publishing this month. The Author, Mr. Gordon-Smith, was with the Serbian army throughout, and writes as an eye-witness of the heroic work of Mrs. St. Clair Stobart's unit during the great retreat, in striving to convey their patients safely over almost impassable routes in the Albanian mountains. Separate sections are devoted to the work of Lady Paget's Red Cross Unit, the Scottish Women's Hospital (N.U.W.S.S.), Mrs. Hankin Hardy's Mission, the Royal Free Hospital Unit under Dr. and Mrs. Barrie, etc.

We have special pleasure in welcoming another edition of Pye's "Surgical Handicraft," in which considerable addition has been made.

We are particularly struck by the suitability of the book for two very different classes of readers, namely, the Student and the General Practitioner. The Student has, perhaps unfortunately, to keep in view the demands of the Examiner, while the practitioner finds it useful to have by him a ready guide in the various emergencies that he may have to face. We venture to say that both are catered for, and excellently well catered for in this book. The arrangement of it is clear and concise, the illustrations are copious and to the point, and the volume makes a ready addition to any man's medical library.

It is interesting to compare the present edition with some of the earlier ones. We have in front of us an old copy of the fifth edition; indeed the student is better catered for in these days. The most notable addition of the edition is that of the chapter on X-rays, the writer having only a limited space at his disposal, is nevertheless clear and concise.

The Medical Who's Who, 1916. Published by the Fulton-Manders Publishing Co. Price 10s. 6d. net.

The current issue of this useful book of reference is again enlarged by about 200 pages, and contains the following interesting features.

Biographies have been supplemented by the inclusion of recent restorations and registrations, and when details have been obtainable a * indicates the names of those on active service, while an obituary list includes the names, similarly indicated, of those who have passed away in the service of their country.

A useful index of towns is given with the names of the resident practitioners, and particulars of medical and nursing periodicals have been given in the cases where particulars have been supplied.

The utility of the volume is undoubted, and those responsible for its production have spared no pains in making their work complete.

The Medical Annual, 1916. Messrs. John Wright & Sons, Ltd., Bristol. Price 10s. net.

In the publication of the present volume there has been special note taken of questions of general naval and military surgery, and the special section at the end of the book is of great interest.

As stated in the preface, the aim has been to aid professional men cut off by the present conditions of war to keep in touch with changes and improvements in treatment which specialised conditions have evolved, and this attempt to give the required assistance has been excellently carried out.

The volume is full of interest, for undoubtedly the pressure of to-day has resulted in an unusual speeding-up of all branches, and although a great deal of the matter published cannot, in any sense, be taken as final, it undoubtedly opens the way to many fields of investigation and research. We thoroughly recommend this volume to every professional man, whatever form his present duties may be taking.

Marriages.

BURNSIDE—GOULD.—On July 25th, at St. Marylebone's Parish Church, Bruce Burnside, M.R.C.S., L.R.C.P., to Grace Holborow Gould, of Bath.

RANKINE—L'ESTRANGE EAMES.—On the 18th ult., at St. Mary's, Henley-on-Thames, R. A. Rankine, R.N., son of A. Rankine, to Lilian, daughter of W. L'Estrange Eames, C.B.

F. A. K.
K. L. B.

GUY'S HOSPITAL GAZETTE.

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Passim.

AT the present time so much is written of the turn of the tide of war and the beginning of the end that we are apt to search our own environment for these cheering signs, and are liable to adapt many really quite ordinary developments to our own conception of the breaking dawn of victory, whereas to us it seems that our true impression of affairs should tend towards a view that from a medical point of view the end is far away. The fact that practically all medicals are now sent overseas rather than to the Western Front is suggestive, in that it is these distant campaigns which take longest to develop and longest to merge into the new establishments of peace, and it seems that those of us who are now putting on khaki can look forward to a well-extended period in which to display the activity of youth, even though the storm of bloodshed and slaughter be on the verge of abating.

ALREADY we hear in Parliament that temporarily commissioned R.A.M.C. officers serving in Egypt, who would, on leaving to serve as doctors, become subject to the provisions of the Military Service Act, have been retained beyond the termination of their year's contract. In making this statement, Mr. Forster added that their retention was necessary in order to provide adequately for medical needs. It was hoped, however, that they might be able to return to this country at an early date, when reliefs were available.

WE are glad to note that, as the result of many letters to the Press upon the suffering occasioned to wounded soldiers and residents in London, both sick and well, by the incessant whistling for taxi-cabs late at night, there appears an immediate prospect that the nuisance may be mitigated. Doubtless the decreased number of taxis upon the streets has called the whistle into unusual activity, but the nuisance has, in residential areas, been a disgrace in London for some years and could well have been put down before our sympathy to the wounded drew attention to the matter.

THE report of the Special Committee dealing with what is known colloquially as "The War Charity Scandal," makes interesting reading to those of medical pursuit, whether directly concerned or not. Like many another matter, it is by no means new, and has been merely accentuated by the war. The report, in this instance, has been followed with commendable promptitude by the introduction of a Bill to deal with the evil in question.

WE hear with regret that Captain Boswell, R.A.M.C., late House-Surgeon at the Hospital, has been wounded. Details are lacking, but we trust it is not serious.

OUR hopeful appeal for details of the more interesting cases from time to time in wards has met with some response, at least in the form of promises, which we hope will materialise in some interesting paragraphs in our future issues.

UNFORTUNATELY we have again to postpone the publication of the photograph of the late Capt. A. Seabrooke, R.A.M.C. The plate prepared for this issue was not considered good enough for reproduction, and a fresh block is being made.

AGAIN we have to chronicle a visit of the nocturnal raiders, and judging from the proximity of the gunfire we may expect, with the lengthening nights, that they have by no means decided to leave us in peace.

Lighting arrangements, and the distribution of the active force of the hospital, appear to us a great improvement on the conditions prevailing last year. However, we sincerely hope they may never be necessary beyond the stage of preparation.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

Herpes and Chicken-Pox.

DEAR SIR,—Ten days ago the mother of two children came to consult me about an attack of shingles on the left thigh. As she left my house I asked her to look out for the occurrence of chicken-pox in the children. To-day I was called in to see both the children, who have very well-marked chicken-pox. The identity or close connection of these two complaints seems well established.—Yours truly,

HERBERT CARDIN.

Stock,
Ingatestone, Essex.
21st August, 1916.

From One Old Guy's Nurse to Another.

21 Stationary Hospital,
Salonica Force,
April 25th, 1916.

Well, here is Easter over, and we had such a nice day yesterday. The C.O. sent out about 300 invitations for sports and tea at his expense. The whole thing was a great success; simply crowds turned up, and our mess sister, with the help of us, undertook to do the tea. On Saturday I was bundled off in the ambulance to town to do some shopping, and on Monday we were cutting sandwiches. It was a perfect day, and the prettiest sports I've ever been to in my life. The races were run on the football ground, about ten minutes from the camp, with rising ground on either side, where the people sat—patients and men one side and sisters and officers the other. Of course, many of the latter rode over, and sisters from all the other hospitals either walked or came in ambulances; in fact, all those who could turned out, and it really was a great day. There was a combined race for sisters and officers. I refused to enter my name, but when the time came for the race someone had entered my name, so I had to go. We drew tickets with numbers, and I was paired off with our C.O. Each sister was given a needle and thread and a button and piece of material. Before starting I made a lovely point to my thread for the C.O., who was to thread the needle, but he didn't approve of it; said he liked a straight edge best, so cut it with a knife. The men stood in a line about 50 yards from us and had to run to us. We gave them the needle to thread, and while my partner was doing his best I tied a knot the other end ready for sewing on the button. but his hand shook so much and the thread was so thick, of course he couldn't get on with it, so I offered to do the job. but no, he wouldn't let me do it, but made for the other end of the thread, and there was the knot, so that was no good. Well, at last it was done; I quickly sewed on the button, and together we ran to the next post, where he was given an envelope with a sum inside to be added up. This done, we joined hands and ran on to the winning post. Of course, all the others had been home long ago, and the sum was wrong! Afterwards I was told by one of the visitors that the C.O. and I were so busy talking that they thought we had forgotten all about the race! There were some very good tugs-of-war and a ripping band from H.M.S. ———, lent by kind permission of the Admiral on condition that "the men were kept blowing and returned sober!" Well, I really must stop now and do some work. It's a very horrid day, pouring with rain and quite cool again.

With best love to you and kind remembrances to your sister, hoping you will get a nice little holiday. My sister quite thinks I shall get leave from here for a summer holiday, but no such luck.—Yours sincerely,

A Landsman with the Fleet.

II.—ON PATROL.

A beatific smile must, I suppose, suffuse my features. I am seated upon a divan in a vast hall, a composite reminiscence of St. Peter's and the Piccadilly Grill, before me a board groans with viands whose consumption in my waking hours would be followed by the bitterest regrets. Somewhere an orchestra plays the morning music from Peer Gynt. "A little *Chateau Yquem,* sir," says a mellow voice in my ear. I nod abstractedly, lost in the delights of Homard à l'Americaine. . . Suddenly the melody trails off into a series of crashes, bangs, and rumbles, the soft amber light becomes broken up into flashes of hideous colour, the happy vision changes to a ghastly phantasmagoria. With a start I awake. The noise, at least, was no delusion begotten of Welsh rarebit at an unwise hour. A rattling of chains as in a vault, a strange grinding and throbbing, the tramping of heavy feet above my head, such a combination of cacophony can mean but one thing, and realising that resignation is the better part of valour, I switch on the little light above my head, feel drowsily for shoes, trousers, and greatcoat, and climb through my hatchway to the upper airs. For a moment I stand bareheaded, letting the soft night breeze clear away the last débris of the ivory gate. Dimly in the offing the grey landmarks flit past, all around dark shapes mark the fleet at anchor; as our speed increases their long hulls and squat funnels seem less than real, more like painted canvas in the prologue to some vast drama. Under my feet the hull throbs and vibrates, and by long experience of such phenomena I know our speed to be between eighteen and twenty knots. Astern and seeming to cut the line of our wake in two I can see another destroyer, its high narrow bows spurning the long plumes of foam at its base with a grave, ascetic motion. Almost obscured by it, another can be dimly seen; looking ahead I note the larger form of a light cruiser, so probably the "stunt" is to be a fairly long one. Crawling beneath the torpedo tubes, now trained on the beam and manned for instant action, I make my way perilously to the bridge. "Hullo, doc!" says a heavily muffled figure, "why aren't you asleep in bed?" I explain why with, perhaps, a trace of bitterness. "Well, there's going to be hell's delight when we get outside; you can feel the ground swell already, and that's always a sign it's going to blow like blazes." True, a somewhat disconcerting motion has been making itself increasingly felt in the last few minutes. "You'll be sick as a dog, I expect," the voice continues; "serve you right for having all that port after dinner. I told you we were probably going to sea." "Oh, dry up!" I murmur weakly.

The bridge of a destroyer is apt to be an overcrowded place. An enormous binnacle flanked by the port and starboard engineroom telegraphs are the dominating objects, around the sides are grouped lookout men, binocular boxes, chart tables, voice pipes, releasing mechanisms for divers explosive charges, the revolution telegraph, and any other miscellaneous gear that a passing whim on the part of the Admiralty or the flotilla commander may consider necessary for our efficiency. In the remaining space the officer of the watch, the captain, and anyone else who may have put in an appearance, in the language of popular nautical fiction, "pace nervously up and down." Directly behind the bridge and at a slightly higher level is the signal platform, where complex messages in codes, whose deciphering would make Sherlock Holmes look a bonehead, are transmitted with an eerie rapidity. The versatility of a leading signalman is a thing to be marvelled at. To be able to control that great flashing arc-lamp alone would, you would think, tax the powers of any but a super-rating. But watch him manipulating those irritating little squares of bunting that wind themselves around wires and stanchions at the first opportunity, plucking them from their pigeon holes, stringing them in correct order, hoisting them, dipping them, lowering and replacing them with a speed that is uncanny. Regard for a while the flapping of those oddly shaped semaphore arms whose endless combinations fascinate the eye, or see him waving flags with arms that never seem to tire, and you cannot but respect a system which from the rawest of materials can produce a like result.

The last buoy has long been passed, uttering a low moaning as it tosses up and down on the waves. The last shore light is rapidly fading away, and already one feels that indescribable sense of *largeness,* of vast open spaces, which is the heritage of all those who go down to the sea in little ships. The breeze has freshened, and at regular intervals a heavy sea strikes us on the beam, swirling green over the stern, making the bridge oscillate like a swing boat at a fair. Firmly wedged between the telegraph and a stanchion, with a strange elation, one awaits each successive shock, gauging its intensity by the height to which that dark wall of sea rises before the vision. Sometimes as she heels over to a heavier blow, there is an interminable instant when she seems to pause at the foot of the abyss as if undecided whether to return or no. For a moment the darkness stands still, shutting out the view, overwhelming in its oppressive nearness. Then, slowly at first, but with gathering momentum, the line of horizon descends, the ship rights herself, and one heaves a quiet sigh. There is little conversation. The middle watch (midnight to 4 a.m.) is a dreary and cheerless time, when life ebbs at its lowest. The first watch, preceding it, has a post-prandial mellowness, seasoned by thoughts of bed; the air at daybreak has the sparkling quality of cham-

pagne, giving the morning watch a great exhilaration. But these long midnight hours have no answering recompense. Sleep is too recent, breakfast and dinner both too remote to lend any comfort to the void of one's being. The look-out men are somnolent and morose, the wind strikes nipping and unfriendly. The sub-lieutenant leans from time to time over the compass, the binnacle light shining up on his young face with a wierd effect of *chiaroscuro*. Seen thus he looks strangely boyish to be entrusted with the destinies of the ship and its crew. It is no sinecure, either, this dark night patrol, where no error, however slight, is venial. Ahead and astern, other destroyers, proceeding at a given speed and in a given direction, rely entirely upon the rigid adherence to these two factors to avoid disaster. Five revolutions more or less might involve two ships in collision, and on a foggy or starless night the blunder might well be irretrievable before it was observed. Small wonder tautened nerves grow irritable under the strain, straining eyes ache and smart with the salt spray. From time to time a few words are passed, orders and queries reduced to telegraphic limits. "Ship two points on the starboard bow," reports the look-out, and even the helmsman who up to now has stood as if hypnotised, raises his eyes for an instant from its fixed scrutiny of the lubber's point.* The sub-lieutenant raises his glasses and scans it closely. "Report to the captain a ship on the starboard bow," he says, after a few seconds, and in less than a minute the captain is on the bridge, keen-eyed and fully dressed. He, too, gives the suspect ship a careful inspection. "Right," says he, shortly, evidently satisfied that she is nothing more than she seems—a homeward-bound tramp. "Wake me up at four; report anything fresh. Keep a sharp look-out, mind. There's some trawlers we've got orders about. What's her course?" "North fifty-two east, sir." "Right, keep her on that!" And the great man disappears to snatch an hour or so of fitful slumber in the charthouse beneath. The entrusting of a ship to a comparatively young, inexperienced officer is not so hazardous as it might appear. Night and day throughout her time at sea the captain is within call; during most of the period he is upon the bridge itself. Even when resting, long practice has given him that cat-like faculty of sleeping with one eye and both ears open. The steering gear and engine-room telegraph shafting pass through the chart-house roof and down the wall close by his head where he lies; any sudden alteration of course or speeding up or slowing down of the ship's revolutions at once rouse him. Very often he appears upon the bridge unsummoned in response to these subtle messages that all is not well. But he is at the same time very careful not to do or say anything likely to undermine his young officer's self-confidence and sense of responsibility. Often in those dreadful moments when a drift of mist or a slight change of course hides the ship ahead, when for a few seconds, at least, the ship is "lost," that last of tragedies in the game of station-keeping, he *knows* well enough that something is amiss, watches his "sub." keenly and speaks no word, noting with silent approval the youngster's resourcefulness and *sang froid*. There are times when the utmost vigilance is hardly sufficient to avert disaster, when collision seems so inevitable that the sharp "full astern both!" is, one thinks, given too late. But accidents are rare, miraculously so. A little incident happened a couple of months back which is not without its humour. A certain destroyer was patrolling a certain, nameless coast. A course was set, to be changed every two or three hours at the end of the beat. The "sub." was on the bridge, the captain asleep in the charthouse. The night was as black as pitch, with a gentle breeze off shore. Suddenly the "sub." sniffed a waft of most delicious perfume. It was somehow familiar, and his mind went back to those happy days he had spent in the country as a boy, the old-world vicarage garden, a well-loved figure with silver hair sat knitting in the sunlight, and all that sort of thing. He rubbed his eyes thinking he had been dozing, but no, the odour of clover was unmistakable. "Do you smell anything?" he said to the look-out man. "Yerse," said that worthy, "it's clover." The captain was sent for; the smell by now was stronger. Just then the look-out spied a white line of breakers, and the mystery was explained. By some error, let us say on the part of the compass, the course, instead of being well out to sea, had been gradualy making for the shore, the land breeze and a field of clover in full bloom explaining the rest. But what the captain said about it would, I fear, be excised by the censor.

G. H. F. G.

*The lubber's line is a point in line with the ship's head, within the binnacle, by which the movements of the compass, and hence the ship's course, are estimated.

Appointments.

Royal Army Medical Corps.

C. R. Nicholson, local rank Major, O.C. St. Ignatius Hospital, Malta.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Some Problems of Infant Nutrition.

By J. H. RYFFEL.

Generalities on infant nutrition are apt to look out of place when applied to certain individuals. Thus an infant is over fed who receives more than one-seventh of its weight in cow's milk, but what of the infant who can consume between a fourth and a fifth of its weight in cow's milk, or its equivalent, and thrive on it? The stomach of the newly-born is stated to have a capacity of one ounce only, but some seem to be born with large appetites. In these matters, also, a study of the individual is necessary for success. The following is an attempt to discuss the practical application of observations which may be made by anyone who has access to a clinical laboratory and has the requisite energy.

Human milk is variable in composition, and is especially so as to the amount of fat it contains. The percentage of fat increases as the breast is progressively emptied, till at the end there may even be ten per cent. of fat. This results in a higher percentage of fat being given to the child when its appetite is good than when it is not. Further, as the child grows older there is a fall in the protein and a roughly equivalent rise in the carbohydrate. With this proviso the average composition of human milk may be taken as: protein 1·5 per cent., carbohydrate 6 per cent., fat 3·5 per cent. In cow's milk there are also large individual variations, but the commercial article tends to be roughly constant in composition with slight seasonal variations, and may be taken as containing protein 3·5 per cent., carbohydrate 4·5 per cent., fat 3·5 per cent.; so that at first sight it appears that to make cow's milk approximate to human milk in composition all that is necessary is to add various quantities of water, cream and lactose. This procedure is, however, not satisfactory in practice, and it neglects important differences such as the ratio of caseinogen to lactalbumen, the high proportion of mineral matter, notably calcium and phosphate in cow's milk, its clotting power, and, finally, the marked difference which exists in physical constitution.

A far sounder plan is to consider cow's milk on its merits as a diet, and to correct it where it proves to be unsuitable. As to concentration there is little difference between human and cow's milk, the protein and carbohydrate taken together are nearly equal in the two cases, and so is the fat, except that in the human the amount of fat is adjustable according to requirements. The tendency of cow's milk to form solid clots in the stomach is minimised by the use of citrate.

In the normal gut equilibrium is maintained between the digestion and absorption of food stuffs and their decomposition by the bacteria of the gut. The more rapidly food is digested and absorbed the less it is influenced by organisms. Other factors which regulate the organisms are the natural antiseptics of the alimentary canal, notably the gastric hydrochloric acid, and the movements of the gut. Further, the various groups of bacteria normally present exert a distinct control on one another, and also tend to overpower new comers. The principal groups of normal organisms are as follows:—

(*a*). *Facultative ærobes.*

1. The B. coli group.—Gram negative mobile bacilli, which decompose protein yielding various basic bodies such as ammonia, indol, and skatol, and decompose sugars yielding gas and acid, but are not highly acid resistant, and do not produce a high degree of acidity in culture.

2. The B. acidophilus group.—Slender gram positive bacilli of variable length with a tendency to grow in chains, which form much acid from sugar with no gas, and have little action on protein. They produce a highly acid liquid, when supplied with sugar, and are highly resistant to acid.

These two groups, 1 and 2, are to a certain extent antagonistic. If little sugar be present in a culture, the B. coli will overgrow B. acidophilus. If sufficient sugar be present, B.

acidophilus will produce so much acid that B. coli is inhibited and ultimately killed. The same relation holds good in the intestine of the infant, excess of protein encourages B. coli, excess of sugar acidophilus. The B. bulgaricus of sour milk is functionally similar to B. acidophilus and overgrows B. coli in a similar manner,

3. The cocci.—These produce considerable acid from sugar without gas, and in the intestine are to be classed rather with B. acidophilus than with B. coli, but they are more versatile than B. acidophilus and include pathogenic organisms.

(*b*). *Strict anærobes.*

4. The B. ærogenes capsulatus group.—Relatively large gram positive bacilli which decompose protein and produce gas and some acid from carbohydrate, and are not highly acid resistant except as spores. Functionally they are to be classed with B. coli as the *protein* group, and are more distinctly putrefactive than B. coli, and probably more harmful when in excess. Combe, in his book on Intestinal Intoxications, speaks of these anærobes as the only putrefactive organisms of the intestine, and classes B. coli with the carbohydrate organisms, but B. coli does definitely decompose protein, and has been shewn to form toxic animes such a iminazolylethylamine.

5. B. bifidus.—A small gram positive bacillus said to grow only anærobically, but is functionally not to be distinguished from B. acidophilus, and is therefore included with it in the *acid* group.

The intestine of the infant can be shown to contain organisms within a few hours of birth, and within a few days the above groups are all normally present, an excess of the acid group being maintained until the child is weaned. Doubtless these organisms are acquired from the mother, and when established they tend to prevent the growth of new comers. When an infant is artificially fed from the beginning, the original infection of the intestine is fortuitous and cocci much more prevalent. It is an interesting speculation, whether some attempt at inoculation with the correct organisms should not be made in a case where no contact with the breast is possible.

The investigation of the balance of bacteria in the fæces of any given case is beset with difficulties. In the direct film gram-negative forms of organisms, which should be gram-positive, are frequent. and as to cultivation there is no known method which will not favour some groups at the expense of others. The presence of excess of cocci, however, can be easily made out and may be so marked as to suggest the desirability of cultivating for pathogenic forms.

Characteristics of the fæces, which will yield information, are their consistency, colour, odour and reaction, and, microscopically, the presence of fat globules, fatty acid and soap crystals, and starch grains, if given. In the urine the presence of diacetic acid and excess of indican are also useful signs.

When an infant is progressing satisfactorily on cow's milk, its stools differ notably from those of the suckling. They are more bulky, more alkaline, and are much lighter in colour. They seem actually to contain less of the normal pigment of infant stools, bilirubin, but the main difference is a preponderance of insoluble calcium salts, calcium soaps and calcium phosphate. The presence of these is partly due to the large amount of calcium in cow's milk, partly to alkalinity of the contents of the gut which allows of their precipitation. The odour of the fæces, the presence of some indican in the urine, and the relative paucity of acid organisms, which can be made out in a film of the fæces, all point to there being more decomposition of protein on cow's milk than in the normal, and, as the products of decomposition are basic, the alkalinity of the gut may be explained in this way.

When the child is not doing well, these differences may be more marked. The stools are markedly alkaline and contain marked excess of soaps—they may be constipated, heavy, and obviously rich in mineral matter—and have an odour suggestive of putrefaction. The urine contains definite excess of indican and may

contain diacetic acid. Everything points to the need for more carbohydrate. When this is added to the milk in a suitable form, all the striking abnormalities disappear. The stools become looser and finally acid in reaction. The odour improves. The film contains more acid organisms, the diacetic acid of the urine disappears and the indican diminishes.

It would thus appear that for the average child also some addition of sugar (maltose or lactose) to the milk is desirable. Sugars always tend to act as a purgative with children under one year, so that the obvious limit to the addition of sugar is the production of diarrhœa. The optimum addition of sugars for the average child is by no means settled yet. With most patent foods it is done freely and generally to excess.

Another characteristic though infrequent abnormality with cow's milk feeding is the presence of fat in the stools, which are light in colour, bulky, and contain flat globules easily visible under the microscope. The remedy is to use skimmed milk, or separated milk, adding carbohydrate if constipation results. Diminution of the fat in the milk from 4 per cent. to 2·5 per cent. is sufficient. In one instance of this condition weight was stationary on cow's milk, and the stools which were bulky contained when dried 74 per cent. by weight of fat and total fatty acid. Diminishing the fat of the milk and increasing the milk to correct for the resulting loss of energy value resulted in an immediate progressive gain in weight, the dried stools containing 34 per cent. of fat and total fatty acid a week later.

Infantile diarrhœa.—I do not propose to consider the history of the bacteriological study of infantile diarrhœa beyond pointing out that the only possible view on the evidence at present available in the majority of cases is, that the cause of the diarrhœa is not a special infection, but an escape of the normal intestinal organisms from the normal control with the result that excessive quantities of purgative substances are produced, the nature of which is not yet definitely settled.

In the commonest type the stools are highly acid, and it is possible that the acid, mainly lactic acid, is the purgative substance, but there is no parallel effect on adults and no experimental evidence to show that acid in the gut is notably purgative to animals. In a recent paper on the subject E. Mellanby has assumed that the active purgative substance is iminazolylethylamine, a decomposition product of protein, because this substance acts on plain muscle and causes diarrhœa, vomiting and toxic symptoms in animals. The paper is valuable in showing the importance of an adequate supply of liquid in the body in diminishing both the absorption and toxic effect of this substance, but the initial assumption is not based on direct evidence, and is against the facts in that decomposition of protein is not conspicuous in most cases.

In a typical case of summer diarrhœa before the stage of collapse is reached the stools are highly acid, are coloured green with biliverdin, have a rather rancid odour, and are rich in acid organisms. The urine is not rich in indican and, at any rate at first, not rich in diacetic acid. All this goes to show that the balance of intestinal organisms has been displaced in the acid direction.

Beyond giving plenty of water by the mouth and saline injections, and a short period of starvation if the child is not too wasted, opinions are various as to the best treatment. The possibilities are—

1. Giving foods which are more easily digested than milk, and therefore less subject to decomposition, such as whey and skimmed milk.

2. The use of intestinal antiseptics and purgatives, such as calomel.

3. Bismuth, kaolin, Fuller's earth, or charcoal given with the milk or separately. These appear to inhibit decomposition and may well diminish irritation.

4. The attempt to restore the balance. Cow's milk, or, better, skimmed milk, in place of a food rich in carbohydrate, is already a step in the right direction.

Finkelstein has introduced a preparation containing ground-up milk curd, which is, however,

difficult to prepare. An easier preparation is diluted milk with dried powdered casein added in amount at least to double the proportion of protein to carbohydrate in the milk. These methods are, at any rate, the most illuminating, and are not incompatible with some of the others.

Not all cases of infantile diarrhœa occurring in hot weather belong to the above type. The occurrence of foul stools, which may or may not be acid, with marked indican and diacetic acid in the urine, will indicate that there is excessive decomposition of protein taking place, which may result in the formation of purgative and toxic substances. Treatment has then to be modified accordingly. Here the use of whey, to which skimmed milk is gradually added, to be later replaced by diluted milk with extra carbohydrate, has at any rate a theoretical justification. Sour milk might also prove useful.

Intercurrent diarrhœa occurring in other infections calls for no special remark: the same principles apply, unless there is specific infection of the intestine.

Change of Address.

P. R. Boswell, No. 33 Casualty Clearing Station, B.E.F., France.

Albert H. B. Kirkman, No. 12 Casualty Clearing Station, B.E.F., France.

Capt. W. T. Chaning-Pearce, R.A.M.C., 96th Field Ambulance, B.E.F., France.

Col. E. C. Hare, 3, Reynold's Close, Golder's Green, N.W.

B. Burnside, Esq., c/o Bank of Adelaide, 11, Leadenhall Street, E.C.

Dr. E. H. Booth, 2, Ventnor Villas, Hove, Sussex.

Lieut.-Col. Sheen, Woodhill, Rhiwbina, nr. Cardiff.

Major C. R. Nicholson, R.A.M.C., St. Ignatius Hospital, Malta.

Surg. Leopold Mandel, R.N., H.M.S. *Vivid*, c/o G.P.O.

Miss B. H. Daniels, c/o Sister-in-Charge, Nurses' Home, B.E.F., France.

Capt. T. E. A. Carr, R.A.M.C., 1st Field Ambulance, 5th Division, c/o G.P.O., Dublin.

Capt. E. G. Goldie, R.A.M.C., Hospital Ship *St. David*, c/o G.P.O.

War Injuries to Knee-Joint.

As this is a subject under much discussion at the present time it may be of interest to give the experience gained from a number of cases. These cases, roughly, fall into three groups:—

A.—Penetrating wounds of joint with small exit and entrance (or entrance only) wounds, with no injury to the tibia or femur. These naturally pass through the anterior part of the joint.

B.—Lacerated wounds of extra-capsular tissues, with primary or secondary involvement of joint.

C.—Compound fractures of lower end of the femur or upper end of tibia involving joint.

Taking Group A: There is practically always an effusion of fluid into the joint, first of clear, non-purulent fluid which may sooner or later become purulent. In these cases it is important to excise the wounds completely as a routine treatment, and as soon as possible. When this is done, fragments of clothing and metal, or loose pieces of bone (from comminution of patella) if present may be removed. The joint should be thoroughly washed out, and the wounds closed. A firm bandage is applied, and the limb placed in a Thomas's splint with extension to ensure absolute rest.

We have had one case where this has proved sufficient, but this is the exception. The joint practically always fills again with clear or purulent fluid. Aspiration should be given a thorough trial, as it is by this means only that a useful and freely moveable joint may be obtained. At the same time a careful watch must be kept on the local and general condition. We should make a special point of the absolute fixation of the limb to prevent the chance of adhesions being broken down, which tend to localise the fluid in the joint. It is in those cases where the whole joint cavity becomes involved that aspiration fails. The synovial membrane, though lacking the "localising" abilities of the peritoneum and omentum, probably has more power to do this than was previously recognised.

If this treatment is of no avail, the local and general condition will demand further drainage. It is important to remember that the attempt to save the joint has now passed, and that the next consideration is to save the limb. The main object, therefore, is to obtain efficient drainage, a most difficult proposition. The methods which have been tried are:—

(1). Multiple incisions into the joint, and an attempt to effect through and through drainage by means of tubes, etc.

(2). Complete opening of joint, removal of semilunar cartilages, cutting the crucial ligaments, and fixing the knee in a position of acute flexion.

(3). Complete excision of joint, the bony surfaces being held apart, while drainage is continued.

With regard to (1), it is important that all the synovial pockets, especially in the posterior part of of the joint should be drained. Afterwards continuous irrigation with saline, eusol, etc., may be tried. This has the disadvantage of requiring constant attention (at present not easily available in Military Hospitals), and also many patients are unable to bear the intense pain sometimes associated with it. When good openings have been made the joint should be thoroughly washed out, at least two or three times daily. By this method many cases have progressed favourably.

Successful cases have been reported when treated by method (2), but of this we have no actual experience.

The practice of excision is now advocated by many. It has to be remembered here that while in joints of the upper limb, after excision, the ultimate aim is movement, in the knee it must be ankylosis with a firm bony union. From the point of view of drainage there can be no doubt that it is beneficial. In many French hospitals it is now the routine treatment to excise all joints with suppurating wounds at once, except the knee, when aspiration is given a few days' trial. The whole point seems rather, that if excision is going to be done, it should be done at once, before there is extensive intra-and perhaps extra-capsular suppuration. The operation at any time is a severe one, but much more so when postponed, with the added *risk of opening up cancellous tissue to acute sepsis.* To obtain drainage the bony surfaces must be held apart until the suppuration has subsided. It seems exceedingly doubtful whether bony union will be obtained here, without a further removal of bone, as it is always apt at any period to relight the inflammatory condition. It would require a great confidence in the procedure to excise at once, as a routine treatment, all cases of suppurative arthritis of the knee.

If in spite of attempted drainage by means of any of the above methods the local and general condition becomes worse, amputation through the thigh should be performed, the position now being to save life and not the limb.

In the class of cases (B) there is usually much sepsis, and if the capsule has been opened, it seems wiser to drain the joint at once. When there is not much sepsis the wound may be excised and an attempt made to close the capsule (after washing out the joint) either by direct suture or by a flap of fascia lata or muscle reflected from the thigh, and aspiration continued afterwards. So far as our experience goes this is seldom satisfactory, and drainage has been necessary afterwards.

In the class of case (C) where there is a compound fracture of the lower end of the femur (condyles only or including shaft), or the upper end of the tibia, the condition is a serious one. It has been our experience that where there is a compound fracture of the upper end of the tibia implicating the joint, the toxic absorption is much greater, and the general condition more rapidly undermined than when the lower end of the femur is compound and the joint involved.

The general opinion now held appears to be that in both types the sooner amputation is performed the better; otherwise risks are run, and the general condition becomes so poor that amputation involves serious risk to life. In any case, it is bad surgery to ruin a good constitution by continued toxic absorption, to try and save what will probably be a useless and constantly painful limb.

No. 9 Red Cross Hospital, B.E.F. August, 1916.

O. G. M.
F. D. S.

Letters from Old Guy's Men on Active Service.

H.M.S. ——,
c/o G.P.O.,
July 31st, 1916.

Dear Sir,

It is nearly a year ago since I wrote to you last, when I was in Gallipoli. After being invalided from there with dysentery to Malta, and eventually reaching England, I was appointed to this ship, of which I am P.M.O. I have an R.N.V.R. Surgeon-Probationer to help me, and two sick berth stewards. This is a very large and roomy ship with a beautiful sick bay, including an excellent operating theatre, a ward of 12 beds, an isolation ward, and an observation ward, each fitted with separate bathrooms. We carry a complement of some 400 men. As to our armament, or our doings, of course, one can say nothing. We belong to a certain cruiser squadron somewhat noted for its lengthy stays at sea, far from the chance of mails, or news of any description. If we receive or despatch mails once in four weeks we have to think ourselves lucky. However, with the aid of a boxing ring, an excellent deck for hockey and cricket, and a variety theatre, we manage to pass the time fairly successfully. Of course, people are inclined to get rather "mouldy" at times after about four weeks without a sight of the "beach," but it all blows over eventually, and when our time for ten days in a home port draws near, things become very merry and bright.

I do all the censoring of the ship. This little job often has its amusing side. One small boy, aged 16,

wrote home the other day, "Dear Parents,—Hoping this finds you as it leaves me in the pink, please send me 11s. your loving son." But such short notes are rather an exception. The ordinary "matelôt" writes about six love letters of about three pages each, and then contents himself with a *post card* to his wife!! One comic fellow the other day evidently knew who the censor was; he wrote, "I am enclosing £1. No, on second thoughts, I'm taking it out, as this letter will be censored."

As to the work, I have had one or two quite strenuous weeks. The first night I arrived in the ship we commenced an epidemic of measles, which ran to some six cases, and then died out again. Since then we have had a couple of fractured forearms, two pneumonias, a greaser who cut most of the flexor tendons of his wrist, and a cerebral hæmorrhage. All these cases we had to keep, as we were miles from such comforts as hospital ships, or shore hospitals. Eventually about a month ago we suddenly got a midshipman with acute appendicitis when far out in mid-ocean, some good four days from the nearest land, so there was only one thing for it: to operate. It is not a too pleasant thing to be let in for your first appendix op. on your own, with only an unqualified surgeon probationer (who by the way had never even worked in the wards of a hospital!) as anæsthetist, and the assistance of two sick berth stewards who had not the first idea of asepsis, and with none to turn to for advice. However, having called the baker in to "bake" all such things as towels and gowns in tins, and with every assistance from the captain, who slowed the ship down to about six knots, to steady her somewhat in the heavy swell then running, we started our operation. Luckily I had managed to teach my surgeon probationer something about anæsthetics previously, and on this occasion I must say he came up to scratch, and did remarkably well under most trying circumstances. On opening the boy up, pus immediately gushed out; the appendix was found; it was gangrenous and perforated, very long, and lying right up almost against the lower pole of the right kidney. We mopped up the pus, and successfully removed the appendix. For the purse-string suture we had no intestinal needles! We got the wound sewn up and a drainage tube inserted, but by the time we finished he had twice collapsed, and had needed artificial respiration and strychnine on each occasion. However, we got him safely to bed and infused him with saline; a week later we landed him "somewhere in Scotland," and he is now well on the way to recovery. I expect "Joey" Hughes will be somewhat amused to hear of my first appendix case!

Still, that week was a jolly anxious time for everyone, especially myself, as I had all the nursing to do, including sitting up with him every night; still, it was a fine experience, and I now find myself longing for someone else to get an attack.

One thing we discovered was that an inflated "Girva" waistcoat makes an excellent air cushion for a patient lying in bed. Well, I hear we are about to rendezvous with a homeward-bound ship, so here goes for making up a mail. More censoring!! So must finish. Cherry-ho.—Yours ever, H. PARRY-PRICE.

---

c/o Cox & Co.,
Bombay,
27th June, 1916.

My dear R——,

I don't know what your rank is now in the O.T.C.—probably Major. I have, therefore, addressed you as a civilian: and hope it will reach you: but Mackenzie Wallis turned up here yesterday as an officer of a stationary hospital, so there is no telling now what may have become of you. I did not see M. W., but his Colonel, who came to lunch with us, is finding him most brilliant and valuable as an assistant pathologist, full of energy and ideas. He has been working on nephritis in France: and also, I believe, diagnosing embryonic war-babies by Abderhalden. They have now left Bombay and gone to Deolali: I am sorry, I should have liked to have seen him. Well, I hope you are thriving: it seems a long time, indeed it is a long time, since your exciting return from Switzerland and the days when we used to discuss the fall of Namur over an Express Dairy tea table. I hear there are great changes at Guy's. I have been M.O. to the 21st Lancers on the North-West Frontier since September, but in May I went off on a month's leave in Kashmir (one of the loveliest countries on God's earth), and scarcely was the month over when orders arrived to proceed to Bombay. So to my great joy I proceeded, and now have the medical ward of a War Hospital for the Mesopotamia wounded, and find things very much more congenial than duties with a regiment. Barber is to be at the same hospital and to have a room in this same bungalow where I am, so we shall no doubt try and do some work together; but at present he is on a hospital ship, doing a trip up to Basra. Unfortunately, too, all our patients are seen fairly late in the disease—a fortnight or so after onset, and as they never by any chance have any papers with them, we are usually at a disadvantage as regards history and diagnosis.

I like Bombay very well, though the monsoon is in full swing, and we get several drenching showers daily; the air is sticky like a hot-house, but we have electric fans and light, and there are green grass and green trees about—a very pleasant change after the intense heat and arid desert of my last station on the Frontier.

I don't suppose I shall see any active service now, though I may go up to Mesopotamia; I hear Rowlands and Davies-Colley are there. They don't want surgeons there just now, for a wonder: many sick, but practically no wounded.

I have been out this afternoon to the wonderful Pathological Laboratory at Parel they make there all

the plague vaccine and antivenin for India, and it is pleasant to watch them extracting the venom from a vigorous six-foot cobra. They have serum at hand in case the man gets bitten, as has happened two or three times. They are starting a school of Tropical Medicine there, which at least will have the advantages of a magnificent building and unlimited material. I think the days when people take the D.T.M. in London or Liverpool are numbered, as they should be.

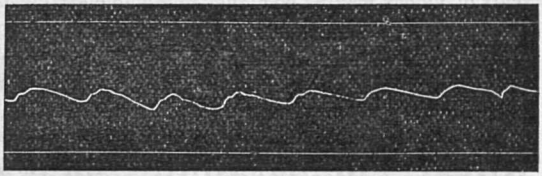
I hope you are fit; I should like to hear what you are doing with yourself.—Yours,

TREVOR B. HEATON.

An Interesting Case of Flint's Murmur.

The patient, G. H., aged 55, was a vigorous healthy-looking man employed by the Croydon Corporation in washing out the sewers, which, if it did not always involve fresh air, was nevertheless an occupation necessitating considerable constitutional strength. His ailments were few and were mainly of the nature of severe colds and influenza in the winter time: apart from these, by his own account, he had a lifelong clean bill of health, with the single exception of an attack of rheumatic fever when six years old. Last May he was at work when suddenly he became breathless and was compelled to rest awhile; his dyspnœic condition did not abate and he consequently knocked off work altogether. Soon a dropsical condition of the legs set in, and he experienced a pain right across the abdomen immediately below the level of the ribs. As he made no progress, he was advised to come up to Guy's Hospital, and he was accordingly admitted into Addison ward under Dr. Shaw who found a well-marked systolic murmur over a large area of the chest and a more localised presystolic murmur in the mitral area; Dr. Shaw therefore made the provisional diagnosis of "Mitral stenosis and regurgitation." The blood-pressure stood at 125 mm.; the sphygmograph tracing showed a marked dicrotic pulse of the anacrotic type. Under digitalis the patient's condition improved: the œdema subsided very largely, the bruits were not so loud and the dyspnœa was less evident, and although he had very sleepless nights, he was able at times to sit in a chair. This improvement was not however to last; the pain in the abdomen increased, the liver which before was not distinctly palpable presented a definite edge some three inches below the right costal border; the action of the heart began to be very irregular and the temperature was generally subnormal, standing at 95° and often below. At this stage he declined very rapidly and finally died in his sleep on Wednesday, August 2nd.

The post-mortem examination showed the customary changes of chronic venous congestion—"nutmeg" liver, engorged spleen, congested stomach, but the condition of the heart was most unexpected. The mitral and tricuspid valves were almost unaffected; but the aortic and pulmonary valves were in an incredibly advanced stage of calcification. The original valve flaps were replaced by thick and hard calcified plates, and were obviously incompetent and stenosed. The corresponding arteries were very atheromatous, and Dr. Shaw was of the opinion that the history of rheumatic fever was of no importance and that it was an advanced case of syphilitic endocarditis. As a possible origin of the presystolic bruit, he pointed out that between two of the cusps of the aortic valve there was what appeared to be a regurgitant channel, and below there was a corresponding atheromatous patch on the aortic segment of the mitral valve. These appearances suggested that the refluent aortic blood stream had held up the mitral cusp and thus produced a spurious mitral stenosis as suggested by Austin Flint.



Dr. Shaw thought that the special feature of the case was the condition of the pulmonary valve which by an acquired endocarditis had reached a stage of degeneration rarely seen even in congenital heart disease and which in the acquired variety is infinitely more uncommon.

My thanks are due to Dr. Shaw and his house physician, Mr. Phillips, for their permission to publish the facts of this case.

W. GOVER.

Too Old at 74.

He's a little fellow, old and wizened, with blue eyes, which seem to have lost their lustre, and small delicate hands which every now and then appear to tremble, yet ever so little. He wears the R.A.M.C. uniform of a major, and carries himself as a soldier for all his years. His record of work would surprise many who still fondly imagine that the limit of man's life is still three score years and ten.

For months now—aye, almost for years, so long sometimes does time seem to stay—he has worked, almost beyond his strength. Certain is it that for more than fifteen months this old gentleman has done his bit. What is his bit?

The past is only hearsay, but of the present and immediate past there is sufficient evidence. The only medical officer of a Field Camp 5,000 strong, a sick parade of 150 or more each day; inoculations and vaccinations in the afternoon; camp inspection, sanitary work, inspection of drafts at odd moments during

the rest of the day; at night filling in returns and playing bridge. Not a bad record at 74; yet always cheerful, possessing a fund of humour and kindly wit, and withall more competent than many a younger man. In these days of compulsion, of the "get-sick-quick" company of conscience-stricken objectors, he, and men like him, still preserve their courage and their hope.

He lavishes the same care over these later Britons who pester him with their childish complaints and sickening excuses, who refuse this and object to that, as over the earlier men, who filled him with pride—an old man of 74.

God! And to see these conscripts, with slovenly gait, who, "as man to man," parade before him. This man, who did his job some twenty years ago and is now bearing two men's burden, and these conscripts! these "This is a free country; I won't be vaccinated!" who make him work overtime because, forsooth, after two years of money-making war, they object to clean clothes and a shilling a day.

He is a brave man, this old boy of 74—braver, I think sometimes, for marking each day some of his hundred and fifty—Duty. W. G. S. N.

Royal Photographic Society of Great Britain.

Most of the photographic societies have ceased to hold exhibitions since the outbreak of the war, but the Royal Photographic Society abides by its old traditions, and is holding its Sixty-first Annual Exhibition at the Gallery of the Royal Society of British Artists in Suffolk Street, Haymarket, from the 21st inst. to September 30th.

According to custom the exhibits are divided into Pictorial, Scientific and Technical, and Colour, and all sections are exceptionally strong; stronger, perhaps, than for many years past, notwithstanding the absence of Continental work. It may be that the restrictions placed upon out of door photography have induced photographers to concentrate their energies upon a few choice subjects rather than to dissipate them over many. Be that as it may, the pictorial work is very attractive. There is little, if any, of a bizarre character, the pictures as a rule showing sound and thoughtful composition and technique. So much is that the case that at a first visit there is little standing out in a way to attract attention beyond their fellows. We may, however, note as a striking example the portrait of Mlle. Rambert as "Virgin with flower," composed and lit after the style of the fifteenth century, by Mrs. Mania Pearson, and a group of Chinese subjects by Horace Jackson.

Landscape and architectural subjects are more in evidence than they have been for some years past, but without diminishing the interest of portraiture and figure compositions, in both of which the American contingent of photographers figure strongly.

The bestowing of medals has been resumed in the Pictorial section, and four have been awarded to Mrs. Alice Choate, Mrs. Mania Pearson, Horace Jackson, and M. O. Dell.

In the Technical Section visitors will be chiefly attracted by three remarkable panoramas of the German trenches photographed by the Printing Company of the Royal Engineers. These striking photographs have been lent by Captain B. H. Wilbraham R.E., D.S.O., with the permission of the military authorities, and are fine examples of the perfection to which the application of photography to the purposes of military intelligence has been brought in our service. All three are telephotographs taken with lenses of from 30 to 72 inches equivalent focal length, one with the ordinary field equipment of the Printing Company, one with a special periscopic camera, and the third with a high power telephotographic outfit. The panoramas, one of which is eight feet long, are produced by making a series of negatives on comparatively small plates and then enlarging two diameters. The cameras have often to be handled under fire, and on more than one occasion have had bullets through them.

Prominent among the exhibits in the scientific section are some solar photographs from Stonyhurst College Observatory, micro-photographs of molluscal radulæ by G. Ardaseer, and some very fine natural history studies by D. Seth-Smith of the Zoological Society, and three autochromes of a kingfisher (a most difficult subject), the nest and eggs of the peewit and the ptarmigan sitting by Dr. F. C. Penrose. Medals have been awarded to these three workers.

Colour photographs on paper are numerous and by a number of methods, in some instances the selection of colour is quite automatic, in others it is due to the photographer's skill and taste.

The section for transparencies in colour (chiefly autochromes) is not a large one, about the same in numbers as in the last three or four years, but the judges have evidently made a careful selection and have awarded medals to Louis J. Steele for figure study entitled "Autumn," to Walshams, Ltd., for a study of the Art Gallery in Buckingham Palace, and to Chas. West for a landscape at Burnham Beeches.

The Trade Section is of an interesting nature, the firms represented being the Autotype Company, Baryta, Limited, John H. Gear's School of Photography, J. J. Griffin & Sons, Limited, Sanger, Shepherd & Co., Kodak, Ltd., The Platinotype Co., and Johnson & Sons, Ltd. The exhibits are principally photographs by well-known photographers on the papers supplied by the various firms, and the Platinotype Co. will demonstrate the working of their papers daily at 3 o'clock, and on Tuesdays, Thursdays and Saturdays at 7.30.

Lantern Lectures are announced for Tuesday, Thursday and Saturday evenings in each week.

Births.

COLLAR.—At West Coker, Yeovil, Somerset, on August 8th, the wife (née Grace Harvey) of Frank Collar, M.R.C.S., L.R.C.P., of a daughter.

MOLLISON.—At 26, Nevern Mansions, S.W., on August 4th, the wife of W. M. Mollison, M.A., M.C., of a son.

F. A. K.
K. L. B.

GUY'S HOSPITAL GAZETTE.

VOL. XXX., No. 735.] SEPTEMBER 9, 1916. [SIXPENCE.

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Passim.

IT is interesting and more than satisfactory to read the recent statement to the House with regard to the medical arrangements in Mesopotamia. Subject to its being understood that the Army Council did not claim that all had been done which should be done, it was understood that on all new boats ordered in the United Kingdom arrangements for securing adequate and proper drinking water had been made. Filtration barges are being sent and supply tanks on various points in the river will be provided. As regards the vessels already on the spot, an installation for sterilizing water, recommended by the Director of Medical Services, had already been provided on many ships, and is being fitted to the remainder. Two tanks, holding 40 gallons for cooling purposes had also been added on each vessel. A great number of hospital river steamers and barges had been ordered. As regards drugs, medicines, bandages and medical appliances, all demands had been supplied and, as the statement concluded, "as the G. O. C. has been repeatedly told to ask for all he wants, we are satisfied that sufficient supplies are now available on the spot."

DURING the war, more particularly in its early stages, one heard many stories of attempted introduction, by enemy agents, of epidemic disease into this country, and the latest, we believe, comes from Bristol, where rats infected with bubonic plague have been caught, although the theory of deliberate infection seems at present by no means established. In this connection, however, may be mentioned the spread of epidemic poliomyelitis which is at present raging in New York. The uncertainty which exists as to the infecting agency in this particular disease makes the difficulties very great. In New York the death-rate has reached the unusual height of 25 per cent. and a great number of adults have been attacked. In view of the congregation of large bodies of

troops under training in Europe it is vital that the infection shall not cross the Atlantic if it can be prevented. The Americans have adopted strict quarantine regulations for travellers leaving infected areas, and it has been suggested that similar regulations—including ten days' isolation—should be enforced on all passengers coming from New York. The latter sounds a drastic and most embarrassing measure, but by all accounts it may become a necessity.

Overheard in the Out Patients' Hall. A little man, with a very large muffler, explains to his neighbour in the medicine queue, "I bin upstairs and seen the throat speshlist."

"Garn. Ow d'yer know yer seen a speshlist?"

With a ring of most absolute conviction comes the retort, "Two doctors looks down me throat and ses 'Say *Ah!*'—an' leaves me alone. Then along comes anuvver and 'e looks down me throat and ses, 'Say, *Ee!*' an' orders me this 'ere medicine. 'Corse 'e was a speshlist!"

THE now famous air raid with its thrilling climax found the Hospital ready and with excitement well suppressed. We should be glad to hear if the gentleman who retreated so suddenly from his point of vantage followed by the sound of falling coals, has made any subsequent investigations as to the real cause of such disturbing sounds.

ON that night the work on the District became more than usually strenuous, but it was a matter of comfort and satisfaction to the Externs to know that the Aerial Defence Committee, like themselves, were in possession of an efficient "Antizeptic."

WE deeply regret to hear of the death of Lieut. W. Bernard Morrish, 6th K.O.Y.L.I., killed in action in France. He qualified L.D.S. from Guy's a few years ago. Going out after dark to inspect trench mortars, he failed to return, and a search party sent out found his body a little later.

WE have just received further letters on the subject of correlation between chicken-pox and herpes zoster. It is pleasing in these days to find interest in such subjects taken up to the point of discussion, as has been so usual in previous years.

Notice.

I, ARTHUR FREDERICK HERTZ, of 17, Devonshire Street, Portland Place, W., Temporary Major R.A.M.C., Physician to Guy's Hospital, M.A., M.D., Oxon., Fellow of the Royal College of Physicians, an English-born subject, son of English-born subjects and of a family domiciled in England since 1820, being the son of William Martin Hertz, of Bradford, grandson of Martin Hertz, of Bradford, and great-grandson of W. D. Hertz, of Leeds, HEREBY GIVE NOTICE that I have assumed and intend henceforth upon all occasions and at all times to sign and use and be called and known by the surname of HURST only in lieu of and in substitution for my present surname of Hertz, and that such intended change or assumption of name is formally declared and evidenced by a Deed Poll under my hand and seal, dated this day, and intended to be forthwith enrolled in the Central Office of the Supreme Court of Judicature. In testimony whereof I hereby sign and subscribe myself by such my intended future name.

Dated 6th September, 1916.

ARTHUR FREDERICK HURST.

Hysterical Deaf Mutism caused by Shell-Shock cured by Suggestion whilst under the influence of Ether.

AN Australian soldier, aged 22, wrote the following letter to his relations on August 21st, 1916:—

"You may be a little surprised to hear that I am in the Hos. suffering from shell-shock, which has taken away my speech and hearing. It is some sixteen days now since it happened . . . We were in the trenches and going for dear life, when two of us spotted a German machine gunner in a hole, so we made up our minds to have him. We made a charge at him, and I just remember getting to him when a high explosive shell burst at my side; it seemed as if it burst inside my head; everything went black. I tried to call out and couldn't, and I could not hear my mates—only just a terrible bursting in my head all the time. I never remembered anything more until I came to on the boat. . . . The Drs. have told me that I will get alright in time. . . . I saw a good deal of France. . . . There is not a young man there who is not in the Army. The girls and women work in the fie——."

The letter ended abruptly at this point, as I then entered the ward. The previous day I had hypnotised him without difficulty, but was unable to make any effective suggestions, as the deafness appeared to persist during the hypnotic sleep, so that the suggestions did not reach his brain and were consequently not acted upon either whilst he remained asleep or after he woke.

He was totally deaf, and had heard nothing at all during an exceptionally violent thunderstorm. He was not only unable to speak, but could make no sound of any kind, and could not cough.

As no improvement had taken place, he was given ether on this second occasion, after being told in writing that it would have the effect of restoring his speech and hearing. He began to struggle after the first few whiffs, and long before he was anæsthetised he began to repeat the word "Mother," first in a whisper, then louder and louder until he shouted it with a stentorian voice that would have filled the Albert Hall. The etherisation was then discontinued, his limbs never having become relaxed. As he came round I told him to say various words, which he repeated after me, and I then carried on a continuous conversation with him. When the effects of the anæsthetic finally passed away, he was talking with a normal voice and his hearing had completely recovered.

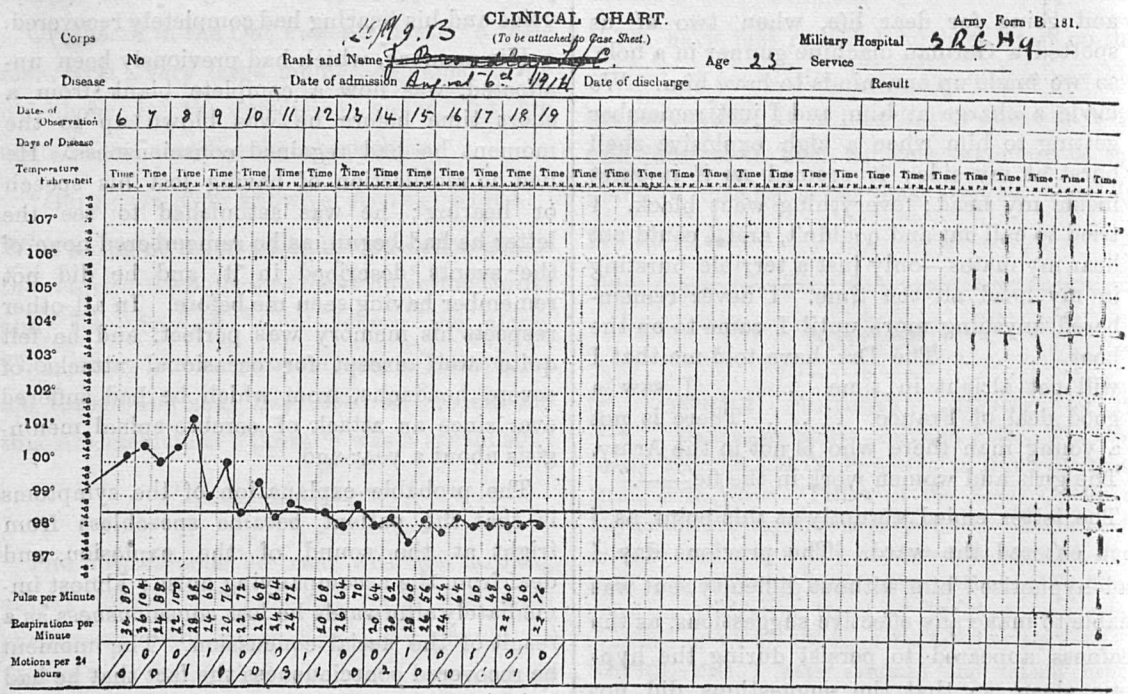
His memory, which had previously been unaffected, was now a complete blank from a short time before he was blown up to the moment he had regained consciousness. He had no recollection of having lost his speech or hearing; he was astonished to see the letter he had begun, as he remembered none of the events described in it, and he did not remember having seen me before. In all other respects his memory was perfect, and he felt quite well except for occasional attacks of severe headache, from which he had suffered ever since an attack of cerebro-spinal meningitis about a year ago.

The probable explanation of the symptoms is that the patient became speechless from fright at the sound of the explosion, and deaf from the accompanying noise; almost immediately afterwards he lost consciousness as a result of the aerial concussion. The moment he recovered consciousness the fact that he had lost his power of speech and hearing after the explosion recurred to his mind, and as a result of auto-suggestion these disabilities were perpetuated. The subconscious inhibiton of speech and hearing was broken down, as a result of the loss of control of the higher over the lower cerebral centres when he was under the influence of ether. By keeping these faculties continuously at work whilst the effects of the ether passed off, their recovery was maintained when consciousness returned. I have no satisfactory explanation to offer for the amnesia.—A. F. H.

Notes of Two Cases of Injury of the Chest.

(1) A Case of Simple Fracture of Ribs causing a Pneumohæmo-pericardium.

The patient, Lance-Corp. B., æt. 23, was admitted on August 6th. The history was that two days previously a weight had fallen on his back while he was leaning forwards.



On admission the temperature was 100°, pulse 80. He was very dyspnœic and cyanosed. Both lungs were very œdematous, and at the time, owing to these pulmonary adventitious sounds, nothing definite could be made out. He was given I.A.H. gr. $\frac{1}{50}$. An examination was made about an hour afterwards, and it was found that the lung œdema had completely cleared up. There did not seem to be any signs of a pneumothorax, but there was a loud splashing heard all over the cardiac area. This sound synchronised with the heart beat, and was clearly heard by the patient. By this time the patient felt perfectly comfortable. He was given I.M.H. gr. $\frac{1}{4}$. He passed a very good night till about 4 a.m., when he again became dyspnœic and very "bubbly." He was relieved almost instantaneously by another injection of atropine ($\frac{1}{100}$). He was again dyspnœic at about 10 a.m. An X-ray examination showed that the cardiac opacity was enlarged to right and left, but there was a definite clear area above and to the left of the main opacity. The chest above the cardiac opacity was quite clear. The diaphragm was not seen on the left side, as the cardiac opacity extended to the extreme left.

The chest was needled from behind, but was apparently empty. A needle was put into the left axilla, and the pericardium, and 10 ounces of blood and a considerable quantity of air were

drawn off. This gave great relief, and except that for a few days the patient became "bubbly" at times and was immediately relieved by I.A.H. gr. $\frac{1}{100}$ p.r.n., he remained perfectly comfortable. After the fluid had been drawn off the splashings became much louder, but gradually went away, and were by August 9th replaced by a rub. This was at first heard over the whole of the cardiac area, but at the time of his transfer on August 19th was limited to the apex, and was not heard with every beat of the heart. The breath sounds were normal. There was a fracture of the fourth rib near its junction with the cartilage, and also of the seventh just behind the postr. axillary line.

The interest of this case lies in the extreme mildness of the symptoms and the rapidity of recovery. The constant slowness of the pulse, which was always regular and of good volume in spite of frequent doses of atropine, may be seen from the accompanying chart.

Another feature of interest was the very prompt manner in which the atropine cleared up the œdema of the lungs and relieved the dyspnœa. He was X-rayed just before he left here for England, and it was seen that the heart shadow was still enlarged slightly in both directions. The chest was otherwise perfectly clear, and both sides of the diaphragm were well defined and moved freely.

C. D.

(2) A Case of Haemothorax in which Clotting interfered with efficient Aspiration.

Pte. B., æt. 23, was admitted on July 21st. He had been wounded in the chest two days previously. On admission there were entry and exit wounds caused by a piece of shrapnel which had penetrated the right chest from before backwards. There were signs of a large right sided hæmothorax, which had displaced the apex beat to the left mid-axillary line.

He was moderately distressed, temperature 100·4°, pulse, 124. He was aspirated on July 26th, till which time I.M.H. gr. $\frac{1}{4}$ was given P.R.N. By aspiration only 20 ounces could be drawn off, although the canula could be moved about freely, and it was obvious that it was in a fair sized cavity. The fluid was reported sterile. The aspiration did not relieve his symptoms and the position of the apex beat remained unaltered. A second attempt was made the next day, but this time only 5 ounces could be drawn off. On August 1st an attempt was made to draw off the the clot by means of a large bladder trocar and canula, the latter being connected with the aspirating bottle. This proved unsuccessful, only an ounce or two of fluid being obtained. The position of the apex beat and the signs remaining unaltered, it was decided to make a large opening into the chest and clear out the clot. This was done on August 5th, *i.e.*, eighteen days after the wound. A flap was raised in the right axilla; about 3 inches of the fifth and sixth ribs were cleared of periosteum; the distal ends of the denuded portions were cut through and the proximal ends nearly so, and this enabled the portions of ribs to be bent back. The pleura was then incised. It was found that there was a fair sized cavity full of blood clot of a very spongy nature. The walls of the cavity were very thick, but that the lung was capable of, at any rate, some expansion, was shown by the fact that the cavity was definitely smaller at the end of the operation. The clot was removed (digitally and with a blunt curette) as far as possible, and was then washed out with the irrigator. The pleura was sutured, the ribs bent back into position, and the periosteum, muscles, and skin were then sutured separately. At the end of the operation the apex beat had come in slightly, but was as far out as the anterior axillary line.

On August 8th (three days later) the apex beat was slightly further out. 15 ounces of clear blood stained fluid and a good deal of air were aspirated. The apex beat was then just outside the nipple. The next day it was in the anterior axillary line. From that time it gradually and persistently came in, and by the time of the transfer of the patient to England was less than half an inch outside the nipple. The signs suggesting fluid persisted on the right side of the chest but a further needling was negative,

CLINICAL CHART.

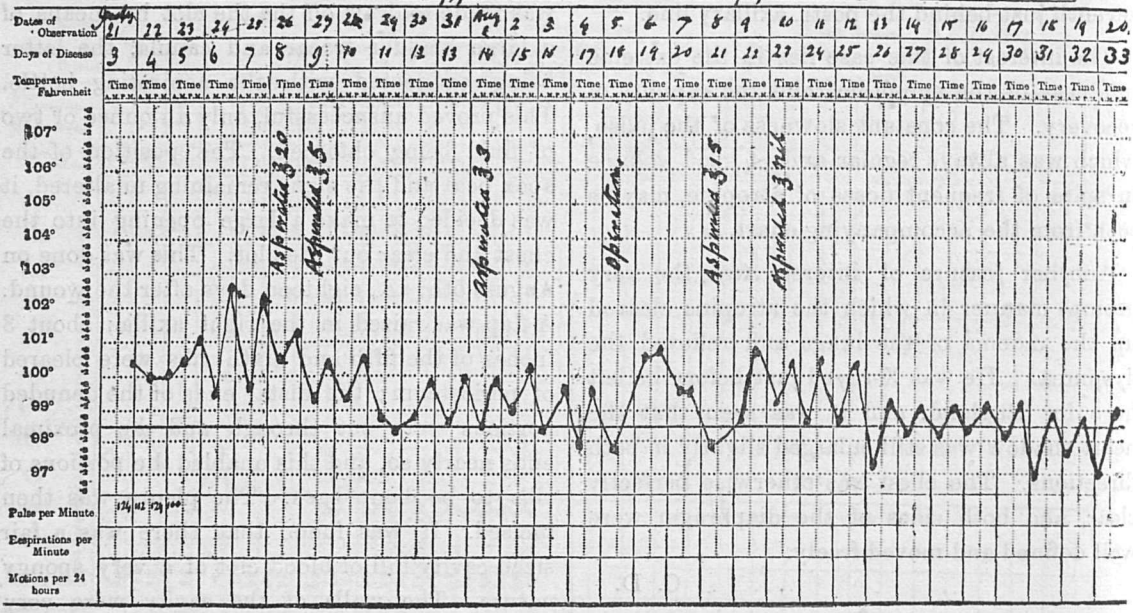
(To be attached to Case Sheet.)

Army Form B. 181.

Corps _____ Military Hospital B.R.C. No 9

No. _____ Rank and Name Pte B. _____ Age 23 Service _____

Disease S.W. Chest - Haemothorax of admission 21/7/16 Date of discharge 20/8/16 Result _____



showing that the signs were due merely to thickening of the pleura. The patient was allowed up on August 11th, and was walking about in a day or so. The wound healed without any sign of suppuration.

The interest of this case lies in the fact that contrary to expectation it is comparatively rare for clotting to take place in a hæmothorax, so that in most cases aspiration is effective. There have been over 80 cases of chest injuries here since the beginning of this year, but in only two cases has aspiration failed to draw off the fluid completely. In the other case a rib resection was done, and the pleural cavity was drained. In that case, though the patient at first was greatly relieved, he became very ill after a few days when the contents of the cavity became septic, and convalescence was very slow and protracted. In all the cases where resection has had to be done on account of sepsis, it has always been found that though the immediate relief is often great, the patients tend to relapse after a few days, and that the temperature does not settle for some weeks in spite of free drainage. In this way their course is very different to that of empyæmata met with in civil life. This may be due to mixed infection occurring, and also to the fact that there is damage to and infection in the lung. Possibly the infection in the lung is intensified after drainage by the increased movement of the latter.

This makes one reluctant to resect at once even in cases where bacteriologically the fluid is

found to be mildly septic, and it has been found that many such cases do very well with repeated aspirations. We have had three cases in which the fluid was infected by Streptococci in which a satisfactory result was obtained without resection. One was aspirated many times, another once, and the third in which the hæmothorax was quite small was not aspirated at all. If, however, there is a large collection, and it cannot be dealt with by aspiration the ultimate result must be so bad that it seems rational to clear out the clot, even though one must run some risk of setting up infection. The hope that a sterile clot will soften and become a fluid one which can be dealt with by aspiration, would seem to be ill founded.

Another point which was shown in this case was the early fixation of the mediastinum to the side to which it had been displaced. In every case where an autopsy has been held in cases of empyæma following wounds of the chest, it has been noticed that the mediastinum was displaced and firmly adherent to the structures of the opposite side, even in those cases where resection had been done in the first week and drainage had been quite free.

F. D. S.
C. D.

No. 9 B.R.C.H.,
B.E.F.

Roll of Honour.

Killed.

2nd Lieut. Edward Mackay Webster, Royal Berks Regiment.

2nd Lieut. D. B. Morrish, West Yorkshire Regt. T.M.B.

Died.

Capt. M. C. Hayward, R.A.M.C.

Wounded.

Lieut. R. Felton, R.A.M.C.

2nd Lieut. E. A. Dawson, 6th Battalion, Somerset Light Infantry.

Temp. Lieut. P. R. Boswell, R.A.M.C.

Lieut. J. N. Martin, King's Royal Rifles.

Staff-Surgeon G. Nunn, R.N.

The Drugged Sweet Scare.

For the last few weeks there has been appearing in the Press in various parts of the country little paragraphs similar to the following, taken almost *in extenso* from the *News of the World*. It is headed "Drugged Sweets: Women Patrols' Warning to Young Girls." Unanimously passed by the Southport Women Patrols, the following resolution has been sent to Major White, M.P. for the Southport Division:—"That the local patrols having recently become aware of the danger to which girls are subjected from offers of drugged sweets, urge that efforts should be made to include them in the Cocaine Act, so that this source of danger may be under control."

Inquiries made with a view to ascertaining what led up to the passing of the resolution show that the story, as told by one of the patrols, was based upon an incident which took place upon the promenade. A patrol regarded with suspicion the manner in which a well-dressed man offered sweets to a girl, who was evidently a chance acquaintance. She interposed, and asked the man if she could have a look at the sweets, but he immediately put them in his pocket and walked away. The patrol then took the girl into a café and explained to her the danger of accepting sweets from a stranger. The girl, who was very young, expressed her surprise. . . . It is stated that this is the first instance of this kind which has come to light in Southport, and that neither the girl nor the man belongs to the town. . . . It is explained that the so-called drugged sweets are ordinary, harmless confectionery purchased from a shopkeeper, and afterwards saturated by the purchaser with a powerful drug."

A letter to the Southport Women Patrols, asking (1) whether any case of actual drugging by sweets had ever been met with, and (2) if so,

what was the drug used and how obtained, met with no response, but a similar letter addressed to Mr. Jones Davies, the Secretary of the Manchester and District Vigilance Association, brought a reply, of which the following are the chief points: "You will observe that in the report of the interview (in the paragraph cited above), I explicitly stated that 'I had never been called upon to deal with such a case.' I can therefore add but little from first hand knowledge.

In dealing with cases such as seek help and advice, the question of drugging frequently comes in. One such sought advice this morning. Her statement is that she took a cup of tea from a man and remembers no more till she found herself alone in a room having been outraged. This, she says, was the beginning of her downfall. *We have no means whatever of verifying this, nor many others that report the same thing with other drinks.*

I should like to add that the clause 'It is explained . . . a powerful drug' (quoted above) was not any explanation of mine. Some years ago these rumours of drugged sweets were more in evidence than they appear to be to-day, and had regard to certain forms of liqueur fondants now largely stopped altogether."

So far, so good. Indeed the question would be without importance, were it not that the prominence given to it by such papers as the *Daily Dispatch*, is an indication of its value as profitable "copy." Readers of the Press will remember the preposterous stories in circulation some three years ago in connection with the upheaval that led to the passing of the Act for flogging bullies.

A vast mass of pornographic literature was put into circulation, as a rule by the less reputable journals, in which under the guise of laying bare a grave social evil, collections of spicy and, of course, purely fantastic stories were allowed into print, and served the two-fold purpose of boosting the circulation of the papers concerned and gratifying the imaginations of the prurient. For months scarcely a ha'penny paper was without its morning *réchauffé* of the apocryphal fainting nun in a cab, or anguished parent too late to rescue his kidnapped daughter from worse than death in the purlieus of Brussels or Buenos Ayres. As was conclusively shown in an article, in the English Review in either June or July, 1914, I am, at the moment, far from means of reference, by a well known lady suffragist and social worker, no single case of involuntary seduction had been proved in England or America during the last twenty years; but the British journalist, engaged in a social purity stunt, having once set his hand to the plough, is not lightly turned back. The stuff sold well, and if the war had not intervened they might be at it yet.

A circular dating perhaps from this period, though it is, I am inclined to think, subsequent to it, has just reached me, issued by a joint committee of all the societies which specialize in the protection of young women. Headed "A warning to girls," it contains a series of cautions, so comprehensive and preposterous, that one is tempted to think the corrupting influence of the cinema is not confined to urchins convicted of petty larceny. "Girls—runs one paragraph—should never ask the way of any but officials on duty, such as policemen, railway officials, or postmen.

"Girls should never accept sweets, food, a glass of water, or smell flowers offered them by a stranger, neither should they buy scents or other articles at their door, as so many things may contain drugs." (!)

"Girls should never accept an invitation to join a Sunday School or Bible Class given them by strangers, even if they are wearing the dress of a sister, or a nun, or are in clerical dress."

And so on. "In conclusion we would say to every woman and every girl in our nation, that we will never rest till this intolerable insecurity,

Captain A. SEABROOKE, R.A.M.C.

Died in Mesopotamia, July 1st, 1916.

which is a disgrace to a civilized country is a thing of the past."

It is difficult for the trained mind to understand the fascination of the world of melodrama. It is in part, I take it, a survival of the older theories of sin and virtue, that convenient doctrine where black is black, and white, white. Either you are a beetle-browed villian, or a white lily of purity, there are no half tones. One would have thought that by the present year of grace, the idea would have died a natural death, but evidently it still lingers in country vicarages and the homes of pious spinsters. The other cause is a very natural diffidence to tackling the real causes of prostitution. It is far easier to issue pamphlets at 3d. a 100, filling the minds of young people with imaginary terrors, than to tell them that the reason a girl goes on the streets is because she is hungry, or demands a little of the joy of life, from which she is debarred. So long as you represent the cause of a girl's downfall as a glib seducer, his pockets full of chloroform, drugged sweets and bogus marriage certificates, the public of wealthy old ladies and country parsons will drink in your words; it is when the picture changes to that of the under-paying employer, the virtuous churchwarden with his shares in a concern deriving its dividends from the underpayment of women, that society holds up its hands in horror, and demands that this thing shall be kept from outraging the morals of their young. A girl, as we said in the story given above, will attribute her prostitution to being outraged when drugged, a reason so foolish that no one but a charity distributing society would believe her for an instant, knowing quite well that the simple and logical plea that she did it because she was hungry would lead to her instant dismissal as a shameless hussy.

The war has done much to sweep away conventional shams and hypocricies. Surely it is time that an end was put to this pornography masquerading under the guise of morality.

G. H. F. G.

Obituary.

2nd Lieutenant D. B. MORRISH, L.D.S.
Killed in action.

We regret to record that another young member of the Dental Association, 2nd Lieutenant Donald Bernard Morrish, King's Own Yorkshire Light Infantry (Trench Mortar Officer), has fallen in action. He was killed in France on August 18th. Lieutenant D. B. Morrish was the younger son of Mr. and Mrs. John Morrish, of 46, Carson Road, Dulwich, and was 25 years of age. He qualified as L.D.S. Eng. from Guy's Hospital in 1913, and had been in practice at Cambridge. He joined the British Dental Association in 1913. At hospital. Morrish was a quiet, efficient worker; popular among his fellow students and all with whom he came in contact.

Change of Address.

Capt. H. V. Leigh, R.A.M.C., from 27th General Hospital, E.E. Force, to 31st General Hospital, E.E. Force, Egypt.

Lieut. J. M. H. Campbell, R.A.M.C., 14, Rawlinson Road, Oxford.

Capt. W. L. Hibbert, R.A.M.C., 23rd General Hospital, B.E. Force, France.

E. Stanley Hoare, M.R.C.S., L.R.C.P., from 17, Bessboro' Street, Pimlico, to 45, St. John's Hill, S.W.

Private D. W. S. Adams, South African General Hospital, B.E. Force, France.

B. Burnside, Esq., Royal Naval Hospital, Haslar, Gosport.

Capt. S. W. Coffin, R.A.M.C., Station Hospital, Malappuram, South Malabar, Southern India.

Surgeon F. G. Lloyd, R.N., H.M. Hospital Ship *Garth Castle*, c/o G.P.O.

Capt. C. Sherris, R.A.M.C., No. 8 Casualty Clearing Station, B.E.F., France.

Capt. L. Horsley, R.A.M.C., from Malta to Poplar Walk, Croydon.

Corrections.

Capt. T. E. A. Carr, R.A.M.C., 1st Field Ambulance, 59th Division, c/o G.P.O., Dublin.

Lt.-Col. Sheen, O.C., 34th (Welsh) General Hospital, Deolali, I.E.F.

An Epitaph.

"Known to the world
As the inventor of 'The Poor Man's Friend,'
He was, indeed, the poor man's friend,
For his life was a comment on the passage
Here is that scattereth and yet remaineth."

* * * *

This is part of an epitaph on a monument in Bridport Churchyard to the memory of Giles Roberts, M.D. Aberdeen, who received his medical education at the combined hospitals of St. Thomas's and Guy's, 1794—1795.

It is probably the only epitaph which permanently advertises a secret remedy; for the "Poor Man's Friend" is a quack nostrum, first produced in about the year 1790 by Dr. Roberts (at that time a druggist and chemist), and still manufactured in the shop he lived and died in, in this year of grace 1916. It is an ointment, which according to the advertisement is for "wounds of every description."

DR. ROBERTS' POOR MAN'S FRIEND
For Wounds of Every Description.

DR. ROBERTS' ALTERATIVE PILLS
For Purifying the Blood.
1/3, 2/9, and 4/8 each.

BEACH & BARNICOTT, LTD., BRIDPORT,
Sole Makers.

Of its composition the writer is unaware.

How a gentleman holding a degree practising as a physician both as a consultant for the South West of England (for we can read of his consultations in Bristol, Exeter, etc., in his autobiography), and, as a general practitioner, came to be manufacturing patent ointments?

The answer is to be found, I think, in the following extract from the "Compleat Family Physician," or, Universal Medical Repository," by Hugh Smythson, M.D., Leyden, and published in 1781.

BOOK IX.

"Strictures on Quackery in General, and a candid Examination of several popular Medicines."

"Where the component parts of a medicine are publicly know as well as the exact manner of preparing it, *or when it comes forth sanctioned by the name of a regular physician of known and approved abilities and integrity, however it is promulgated, or in whatever way the diseased are supplied with it, we do not apprehend that in either case the medicine ought to be considered quackery.*" Shades of the B.M.A.!

Then follow chapters on various legitimate (if they may be so termed) quack medicines, *e.g.*, "Dr. James' Powder," "Norton's Anti-scorbutic Drops," "Ward's Drops Pills and other Medicines," "Sir John Hill's Medicines." Of these, Dr. James' Powder or James' Fever Powder has been handed down to us in the form of the Pulvis Antimonialis B.P.; Ward's Paste as the Confectio Piperis B.P. Of the others they have been lost in the limbo of antiquity.

There is also a modern well-known example of a medicine manufactured by a secret process and which was accepted by the profession, and that is Erlich's Salvarsan.

Honours.

Military Cross.

The Military Cross has been awarded to:—

Temporary Capt. E. H. Griffin, R.A.M.C., for conspicuous gallantry and devotion to duty in action. Without food or sleep he worked incessantly tending the wounded of his own and other units under heavy fire. He showed an absolute disregard of danger. On other occasions he has done similar gallant work.

Capt. G. H. H. Manfield, R.A.M.C, for conspicuous gallantry and devotion to duty in action. He worked day and night tending the wounded in our advanced positions under heavy fire, and carried many of them down the trench after all his bearers had been wounded.

Temporary Capt. H. A. Pallant, for conspicuous gallantry and devotion to duty when attending to the wounded under heavy fire. Later he voluntarily acted as stretcher bearer and helped to carry off nearly forty wounded under heavy shell and machine-gun fire.

Rough Notes on Anæsthetics.

THE war has made me interested in Anæsthetics, which I took up afresh about 15 months ago with the view of helping. I suppose, including gas, I have seen a thousand administrations, three-fourths of which I have myself given. What strikes me in watching, talking about, and reading about anæsthetics, is the diverse views and rules of the authorities.

Some men will not touch Ethyl Chloride, but many others find it most useful on account of the rapid recovery from the anæsthetic, and have not found it to be unsafe. It is also most useful in subduing a noisy second stage under a general anæsthetic. If ordinary care is taken, so that any case not in a proper state of health is rejected, Ethyl Chloride is not dangerous. Air can be allowed along with it when the operation is not in the mouth.

It is the daily custom with some anæsthetists to begin with chloroform for a short time, but some writers lay down the law that you must not induct with chloroform, while many others not only begin but continue and end with chloroform. Again, some object to the use of chloroform after ether in a fairly long operation, while others (as at St. Bartholomew's Hospital) regularly adopt the gas-ether-chloroform sequence. In reality chloroform can be given usefully at any part of an operation according to requirements.

From what I hear it is becoming more common to recognise that chloroform is the best. Mr. Gill, of St. Bartholomew's Hospital, hardly gave anything else. A leading ear, nose, and throat specialist, with whom Sir F. W. Hewitt used to work, told me that Sir F. W. Hewitt latterly used chloroform only in preference to all others. Tom Bird, of Guy's fame, told me recently, that he had come to the same conclusion, remarking "that they all come back to chloroform" in the end, and there are other leading men in London who use nothing else.

The crux of the whole matter seems to me to be the way everything is given. A sudden change from ether to chloroform, or *vice versa*, from chloroform to ether, causes discomfort and upsets the breathing for a time, but if one passes from one to the other by the intermediate use of the C. E. mixture no inconvenience is caused.

The head anæsthetist of a large London hospital said to me "It does not matter so much what is given, it is the person who gives it that counts."

Habits of observation and concentration come in most usefully to an anæsthetist. He cannot have too sharp eyes and should refuse all distraction, while he should be one who enjoys the special work, for it certainly has its infatuations and is full of mercy in its workings.

The reasons given for the use of a Clover apparatus, and other big ugly face pieces which block the view, do not seem to me to be good enough. A simple gauze-covered mask, which is very cleanly, is all that is needed. My own common custom is to begin with chloroform for a few minutes, then pass on to the C.E. mixture for a time, and then on to ether. Having ascertained how long the operation is likely to last I go back the same way from ether to C.E. mixture, ending with it or with chloroform.

I hope these rough notes will make it easier for those commencing the use of anæsthetics, since they record my own experiences.

A. WITHERS GREEN.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Case of Abscess at the Base of the Tongue causing œdema of the Glottis and Sudden Death.

A man about 65 years of age, a fruit hawker by trade, suddenly fell down in the street and expired almost immediately. He was brought to the hospital dead. There was nothing at the time to indicate the cause of death, and the only history one could get was that he had been suffering from a sore throat for a few days and had been taking chlorate of potash tablets, some such tablets being found in one of his pockets.

On post-mortem examination his lungs showed evidences of bronchitis, his larynx was very œdematous, and a soft round nodule was found at the base of the tongue in front of the epiglottis under the mucous membrane. The rest of his organs were apparently normal. A little food was present in the stomach. The nodule was examined and found to contain pus which was sufficient to cause the œdema of the larynx. Considering the suddenness of the death, it is interesting that the patient complained of nothing more than sore throat. He was well enough to carry on his trade as a hawker, apparently suffering no dyspnœa or dysphagia.

I am indebted to Mr. Mollison for having examined the nodule, and to Mr. R. W. P. Jackson for helping me with the post-mortem.

S. W.

Notice.

Dr. Hertz has resumed :—

1. Neurological O.P.'s.—Wednesdays,
2. Do. Clinic.—Wednesdays, 12 p.m.
3. Clinical Lectures.—August 30th (Dysentery), and September 13th (Trench Fever),

Though stationed at Oxford he has made arrangements to attend as above. L. B.

Appointments.

Royal Navy Medical Service.

Temporary Surgeon E. C. de M. Morgan to the *Victory*, additional for Haslar Hospital.

Staff-Surgeon A. J. Wernet, M.B., to the *Leviathan*.

Temporary Surgeon E. W. Harrison to the *Pembroke*, additional for Chatham Hospital.

Fleet-Surgeon E. S. Tuck to the *Egmont*.

Royal Army Medical Corps.

Major (Brevet Lieut.-Col.) W. Hind to be temporary Major.

Major F. F. Burghard, C.B., R.A.M.C.(T.F.), to be temporary Colonel.

Lieut.-Col. H. J. Roberts, M.D., F.R.C.S. (T.F. Res.), to be temporary Major.

Temporary Lieutenants to be temporary Captains :—C. C. Holman, M.B., F.R.C.S., R. Fell, W. C. McN. Dicky, G. M. Brown, H. W. Pigeon, W. Elwood, W. P. Taylor, B. B. Metcalfe, N. Instone, C. A. E. Ring, R. C Poyser, A. Scott, J. Walker, P. R. Boswell.

To be temporary Lieutenants :—A. H. Turner, W. H. Robinson, A. H. Davies, W. S. Kidd, H. R. Marsh, A. F. W. Denning, R. L. Portway, W. J. Vance, P. Rose, H. W. Heasman, E. Evans, H. P. Aubrey, H. E. H. Mitchell, H. S. Knight, S. C. H. Bent, P. C. V. Bent, V. T. C. Bent, G. Lewin.

To be temporary Hon. Lieutenant :—D. O. Richards.

Temporary Lieutenants relinquishing Commissions :—W. A. Smith, L. G. Nash, T. Heatherley, E. W. Goble, T. F. Wilson, C. F. Fothergill, J. E. Prentis (on account of health).

Cadets from the London University O.T.C. to be Lieutenants :—A. Reeves, J. M. N. Campbell, P. D. N. Chapman, R. S. Aspinall, G. E. Kidman, R.A.M.C. (Territorial).

Special Reserve of Officers :—Lieut. W. Williams, M.B., to be Captain ; R. H. C. Pryn to be Lieutenant.

North Midland Clearing Station :—Lieut. C. S. J. Kearney to be Captain.

London Casualty Clearing Station :—Lieut. F. A. Dick to be Captain.

Eastern General Hospital :—Major R. A. Milligan is seconded.

Attached to Units other than Medical Units :—Major W. A. Smith.

East Lancashire Field Ambulance :—J. S. Cooper to be Lieutenant.

Capt. W. R. Reynolds having ceased to be employed with the Australian Voluntary Hospital has relinquished his temporary commission.

Promotion.

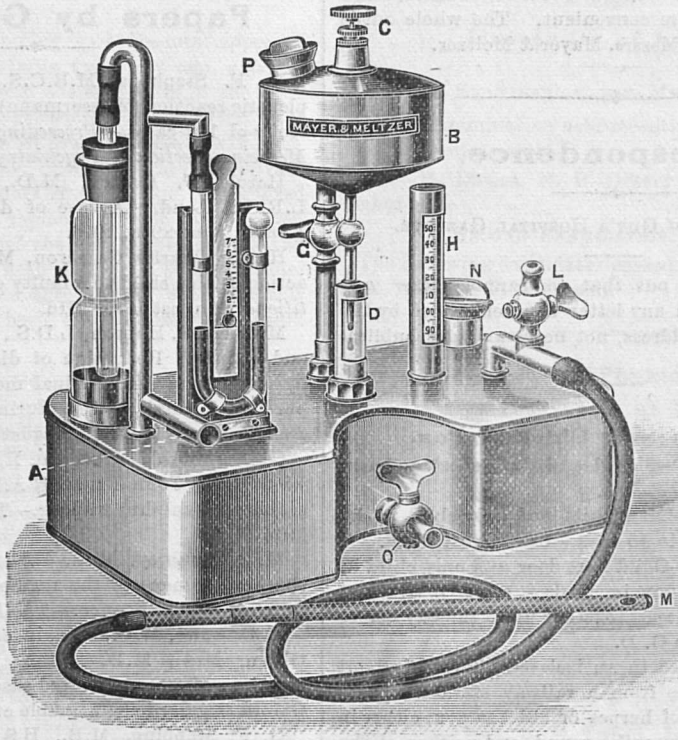
L. Horsley, R.A.M.C., to Captain.

A New Apparatus for the Intratracheal Insufflation of Ether.

BY FRANCIS E. SHIPWAY.

THE principles of intratracheal insufflation of ether have been described by me in the GAZETTE, May 23rd, 1914, to which I would refer any who are without knowledge of the subject and wish to understand the why and the wherefore of a comparatively novel method of anæsthesia which is frequently in use in the theatres. This method has well held its position since it was introduced, and steadily gains ground, the chief obstacles to its progress being not the difficulty of the technique, but the difficulty of passing the catheter, the size and the price of the outfit. There is no reason why any anæsthetist should not overcome the first, after a little instruction, by practice and perseverance; the second and third are almost entirely surmounted in the apparatus here described. Undoubtedly further improvements will be made, but at the present moment a light and inexpensive outfit can be obtained.

The idea underlying this apparatus is that ether drips from a metal container (B) into a central chamber, through which passes the air current (A) from the motor or foot bellows, and is there vapourized, partly by this means and partly by the heat imparted by an encircling hot-water jacket. The tap C regulates the flow of ether, which can be delivered in drops or in a continuous stream, and is visible at D. There is no possibility of liquid ether being blown over to the patient. The tube G, connecting the ether container and the vapourizing chamber, equalizes the pressure on the upper and lower surfaces of the ether, and regular dropping is ensured. During anæsthesia, the tap of the equalizing tube must be kept open, but if the container needs refilling during an administration the tap must be first closed before the bung of the filling funnel (P) is removed, and kept closed until P has been replaced. K is the safety valve, which can be adjusted to blow off at any desired pressure, but is usually set at 30 mm., I the manometer, and L the tap on the exit tube for reducing pressure at regular intervals. The hot-water



jacket is filled at N and emptied by opening O; it stands in a non-conducting cover. An electric heater can be supplied which saves the bother of continually renewing the water. The thermometer (H) should register 110° to 120° F., according to the temperature of the room and the nature of the operation. A Y-piece provided with a tap is fixed in the tubing from the motor-blower (or foot bellows) for attachment to an oxygen cylinder.

The apparatus is carried in a light case made of three-ply wood, fitted with a tray which takes gag, mask, drop-bottle, laryngoscope, etc., so that the whole forms a compact and complete outfit, the

apparatus itself weighing only 5½ lbs. and measuring 8½ by 4½ by 12 inches. It is easy to use and gives a fine adjustment of the depth of anæsthesia. As soon as the catheter has been passed, connected up to the exit tube, and the air current turned on, C is unscrewed and ether is allowed to drip fairly fast until any spasm or coughing has passed off. The rate of flow is then decreased and regulated according to the necessities of the case; a little experience soon shows what the rate should be.

If a foot bellows is used it should be of suitable size, to prevent too great a strain being thrown upon the anæsthetist during an operation which may last an hour or more, for a continuous current of air must be supplied. A filter for cleansing and moistening the air must be attached to it. If a motor-blower is used, a wash-bottle half filled with water is a better filter, since it is efficient and more convenient. The whole outfit can be obtained from Messrs. Mayer & Meltzer.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

DEAR SIR,

Re Herpes and Chicken Pox.

D. D., aged 69 (M.)—Shingles of right chest and arm on 22nd July, 1916.

O. D., aged 4 (F.)—Grandchild and only child in the house. Chicken pox in 15 days.—6th August, 1916.

H. H., aged 5 (F.)—Child next door and only child in the house. Chicken pox in 15 days after O. D.—21st August. They had played together up to the day before the spots came out on O. D.

These cases occurred in an isolated village of about 100 people, five miles from a railway station. There were no other cases of herpes or chicken pox, either in the village or for many miles round, and neither of the three had been out of the village for some time. As the schools were closed there have been no more cases at present, and I do not expect any more as there are no children very close.—Yours faithfully,

C. THOMSON.

DEAR SIR,—Certainly there is a resemblance between these conditions, for the plebeian will describe both as "little blebs, like." Dr. Cardin's evidence of identity reminds me of the man who "died after a Zeppelin raid." Varicella is a general disease, shingles a local. Has anyone ever described chicken pox eruption as following nerve trunks, or a case of shingles that didn't?

Has Dr. Cardin ever encountered the intense neuralgia of shingles in a case of chicken pox? The majority of children have chicken pox; an insignificant proportion of adults ever suffer from shingles. The only post hoc evidence of any value would be for Dr. Cardin to warn all mothers of "varicellar" children to look out for shingles on their own persons ten days or so afterwards. So, perchance, he might get, in the fulness of time, another link in the chain of evidence establishing the identity or close connection of these two complaints.—Yours truly,

Eagle House, Blandford. A. READ WILSON.

Papers by Guy's Men.

H. F. Stephens, M.R.C.S., L.R.C.P.: The compleuetic reaction (Wassermann) in amentia. An original study of 100 cases.—*Proceedings of the Royal Society of Medicine (Section of Psychiatry)*, June, 1916.

Harold F. Renton, M.D., B.S. Lond., M.R.C.S., L.R.C.P. Lond.: A case of double cervical rib.—*The Lancet*, June 29th, 1916.

Hector Charles Cameron, M.D., F.R.C.P.: The reaction of the child to a faulty environment.—*The Practitioner*, August 19th, 1916.

Montagu F. Hopson, L.D.S., R.C.S. Eng.: Appliances and splints. Reduction of displaced portions of bone by immediate and gradual methods, and retention of parts in normal position during the period of union.—*British Dental Journal*, August 1st, 1915.

Captain Stanley Hodgson, R.A.M.C., in collaboration with Major John Bruce, R.A.M.C. (T.): Treatment of scabies by sulphur vapour.—*The B.M.J.*, August 5th, 1916.

M. S. Pembrey, M.A., M.D. Oxon.: Observations on the development of the regulation of temperature and its clinical significance.—*The Lancet*, August 5th, 1916.

E. C. Lowe, M.B., B.S., in collaboration with Ernest Glynn, M.A., M.D. Cantab., F.R.C.P. Lond.: Serum reactions of 300 unselected cases of "enteric" with the Oxford standard agglutinable cultures.—*Ibid.*

G. F. Stebbing, M.B., B.S. Lond., in collaboration with F. W. Tunnicliffe, M.D. Lond.: Intravenous injection of oxygen gas as a therapeutic measure.—*The Lancet*, August 19th, 1916.

Hildred Carlill, M.D. Cantab., M.R.C.P. Lond.: On the gluteal fold in sciatic neuritis.—*Ibid.*

Herbert French, M.A., M.D., F.R.C.P.: Syphilis of the cardio-vascular system.—*The Clinical Journal*, August 23rd and 30th, 1916.

William E. Robinson, M.D. Oxon.: Death after nitrous oxide—Oxygen and spinal anæsthesia.—*B.M.J.*, August 26th, 1916.

T. F. Brown, D.S.O., M.R.C.S., L.R.C.P. Lond.: The use of picric acid in war surgery.—*The Lancet*, Sept. 2nd, 1916.

Letters from Old Guy's Men on Active Service.

Mesopotamia,
July 21st, 1916.

DEAR SIR,—I was very interested to read a Clinical Lecture by Mr. Fagge on Liver Abscess in the last GAZETTE that reached me. He, very rightly, foresees that tropical diseases will be commoner in England after this war than in the past, and the lay public will expect the G.P. to know more about them than here-to-fore. I was surprised to find him describing Rogers' method of treatment by aspiration as "out of date," and feel sure that most surgeons with Indian experience will differ from him.

I believe I am right in saying it was the most approved method of treatment in India two years ago, and was daily winning converts from the adherents of the open operation. In my small experience it has given most satisfactory results; my most dramatic case was in 1912, in Quetta, when I was called upon to operate on a private in the Royal Welsh Fusiliers by aspiration. I removed fifty ounces of pus and replaced it with eight or ten ounces of quinine solution; the man immediately began to improve and put on flesh daily. A small residual abscess had to be tapped three weeks later, but this was only a temporary set back, and he made a splendid recovery.

The advantage of aspiration is the avoidance of a sinus, and of the risk of secondary infection. Residual abscesses and secondary aspirations do not detract from the value of this simple operation.

Mr. Fagge rightly emphasises the value of emetine in amœbic dysentery and pre-suppurative hepatitis, and I am not sure that bold administration of this specific has not, in some cases, aborted a liver abscess after suppuration has commenced; I have no books of reference to hand, but believe such cases have been recorded.

One of the first cases in which I used emetine was in Karachi in September, 1912, where I was called to see a gunner who was thought to have a liver abscess. His appearance was typical and his liver enlarged and tender, but several exploratory punctures failed to locate the pus. I therefore recommended emetine, and within twenty-four hours the sweating and fever ceased, the pain was much relieved, and he was a changed man; repetition of the dose had further gratifying results, and in 48 hours I was able to return to Quetta confident that an operation would not be necessary. I heard subsequently that his recovery was un-interrupted.

Emetine has as specific an action in amœbic dysentery and its sequelæ, as quinine has in malaria, and those of us who had treated dysentery before 1912, rise up and bless the name of Leonard Rogers who put Emetine on the market in that year, after much patient and careful experiment.

The original work of Sir Leonard Rogers in cholera, dysentery, and Kala Azar, to mention only a few of his activities, has saved more lives than all the German hordes have destroyed in this world's war; and he has had the satisfaction, not given to many men of science, of seeing the successful and far reaching results of his work.

We in the Indian Medical Service are proud to belong to the same service as this great man.—Yours, etc.

C. H. REINHOLD,
Capt. I.M.S.

Pass List.

University of London.

FIRST EXAMINATION FOR MEDICAL DEGREES.

At the Examination held recently the following candidates were successful:—

K. J. H. Davies, N. B. Dreyer, A. McKenzie, P. C. Richardson.

SECOND EXAMINATION. PART I.

The following candidates passed.—S. Cohen, L. Lyne A. E. Sawday, P. Couacaud.

Royal Colleges of Physicians of London and Surgeons of England.

FINAL EXAMINATION.

At the Examination held lately the following candidates were successful:—

Medicine.—R. L. Portway, M. B. M. Tweed, W. J. Vance, C. L. Odam, R. H. S. Pryn, H. S. Wacher, E. S. Phillips, B. E. Jerwood, F. N. Sidebotham, R. R. Traill, P. D. H. Chapman.

Surgery.—J. A. M. Alcock, R. R. Traill, G. E. Kidman, A. M. Ahmad, E. C. de M. Morgan, L. S. Gathergood, I. Tewfik, J. A. Martin, J. F. Carter-Braine.

Midwifery.—M. B. M. Tweed, J. A. M. Alcock, W. J. Vance, C. L. Odam, R. H. C. Pryn, E. A. Leviseur, H. S. Wacher, J. E. E. Robillard, D. V. Halstead, M. C. Joynt, A. W. A. Davies, J. E. Ellis, G. E. L. Simons, L. H. B. Evans, R. Aspinall-Stivala, H. Sterne-Howitt.

FIRST EXAMINATION AND PRELIMINARY SCIENCE, L.D.S.

At the last Examination the following candidates were approved in the undermentioned subjects:—

Chemistry.—D. J. O'Meara, H. O. Holmes, H. V. Croucher.

Physics.—A. J. O'Meara, M. Hall, H. O. Holmes, H. V. Croucher.

Biology.—E. F. Wilson, J. E. W. Wright, L.D.S., Eng.

PRELIMINARY SCIENTIFIC EXAMINATION, L.D.S.

At the recent Examination the following candidates were successful in the undermentioned subjects:—

Chemistry.—D. J. O'Meara, H. O. Holmes, H. V. Croucher.

Physics.—D. J. O'Meara, M. Hall, H. O. Holmes, H. V. Croucher.

Elementary Biology.—E. F. Wilson.

Biology.—J. E. W. Wright.

Royal Colleges of Physicians of London and Surgeons of England.

At a Meeting of the Committee of the Royal College of Physicians and Council of the Royal College of Surgeons, on July 27th, the Diplomas of the L.R.C.P. and M.R.C.S., were conferred upon the following candidates who have complied with the respective by-laws:—

A. M. Ahmad, R. Aspinall-Stivala, P. D. H. Chapman, L. S. Gathergood, B.A. Camb., C. E. Jerwood, G. E. Kidman, E. C. de M. Morgan, E. S. Phillips, R. S. Portway, R. H. C. Pryn, I. Tewfik, R. R. Traill, W. J. Vance, H. S. Wacher.

Society of Apothecaries of London.

At the recent Examination the following candidates were approved in the undermentioned subjects:—

Surgery.—W. Burridge (Sections I. and II.), L. A. B. Moore (Sections I. and II.).

Medicine.—W. Burridge (Section I.), H. St. H. Vertue (Sections I. and II.)

Forensic Medicine.—W. Burridge, H. St. H. Vertue.

Midwifery.—W. Burridge.

The Diploma of the Society was granted to L. A. B. Moore, entitling him to practise in Medicine, Surgery, and Midwifery.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Growth in Length. By R. Assheton. Cambridge University Press. Pp. 104. Price, 2s. 6d.

This is a reprint of three lectures delivered at Guy's Hospital during January and February, 1913. In addition a fourth chapter concerning the mechanical factors at work in the invaginating gastrula of amphioxus is added. The first three chapters give an admirably lucid account of the earlier embryology of the various phyla, in so far as the author finds it of support to his contention that growth in all embryos is primarily protogenetic, and secondarily deuterogenetic. Growth in length is ascribed to this second growth centre localised in the blastopore rim of some blastoderms, and to the primitive streak of others. Although much anatomical and experimental evidence is brought forward to uphold this view, the author is occasionally led to conclusions that some of us find difficulty in accepting. It is difficult to believe that the metamerism of the annelid is only analogous to that of the Chokdate and nothing more, p. 62. So, too, on p. 63, an attempt at explaining what object there would be in the change of the axis of the body relative to the blastopore during the evolution of the various phyla would prove welcome. To those readers not eminently versed in embryology, Chap. IV. will prove the most interesting. It forms an attempt to explain the invagination of the embryo of amphioxus on mechanical grounds, rather than on Driesch's mystical Factor E (Entelchy). By means of models the author has successfully imitated this phenomena, and has shown that such mechanical factors as are necessary are present in the actual embyro. A point which lends conviction to this demonstration is that the positions of the nuclei of the various cells are determined from figures supplied by other authorities. The remarkable way in which the author's deductions fit the hitherto unexplained failure of $\frac{1}{8}$ embryos to develop seem to render a belief in Entelchy unnecessary when considering the present facts.

The death of the author was announced in the columns of the GAZETTE last year; this book forms grim proof of the loss his death has meant to the English School of Embryology.

Births.

LITTLEJOHNS.—On July 18th, at Trevarthian Terrace, Stoke Devonport, the wife of Major A. S. Littlejohns, R.A.M.C., of a son.

POMEROY.—On the 16th ult., at "Innistree," Woking, to the wife of Lieut. J. M. Pomeroy, R.A.M.C., a son.

TOOTH.—On August 27th, at 72, St. Paul's Road, Bristol, the wife of Frederick Tooth, Capt. R.A.M.C. (T.F.), of a daughter.

Deaths.

TICEHURST.—On August 10th, at Playden, Charles Sage Ticehurst, M.R.C.P., M.R.C.S., L.R.C.P., L.S.A. Lond., late Surgeon-Major (V.C.), 3rd V.B. (Duke of Cornwall's Own) Hants Regiment, aged 69 years.

HAYWARD.—On 23rd August, at the Howard House, Brighton, from acute septic pneumonia, Milward Cecil Hayward, Captain R.A.M.C., son of the late Henry Howard Hayward, Queen Anne Street, London.

F. A K.
K. L. B.

GUY'S HOSPITAL GAZETTE.

VOL. XXX., No. 736.] SEPTEMBER 23, 1916. [SIXPENCE.

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Passim.

IN the past, it has been the custom to publish a Students' Number of the GAZETTE during the later days of September, but owing to the growing demands of the Army and the resulting change in the relationship between the intended medical student and the School, it has been decided to depart from the old lines and at least temporarily to alter the dedication of our special issue. The suggestion has been that we should strive, not to attribute any particular objective to our coming flight into twenty-four odd pages, but only to pursue our present day policy of accumulating as much matter of general and local interest as possible. We must exhibit a degree more vigour than usual, and trust in a corresponding degree of success.

Thus we hope to publish merely the same heterogeneous matter, varying, as our readers tell us, with politeness often spontaneous, sometimes forced, from the most excellent to the most futile. It will have this, perhaps questionable, advantage—There will be more of it. Editorial activities can do much good in this attempt, but the contributor's response can do far more, and we most urgently appeal to all for some addition, however small, to the voluminous piles of copy steadily accumulating in the Gazette Office. Such at least is our dream, and though a survey of previous editorial dreams is hardly encouraging, we will continue in our hope until the end.

IT is with the deepest regret that we hear of the death in action of Capt. G. S. Miller, R.A.M.C. Later, we publish several letters from his brother officers, and all show that he was as brilliant and popular in his new sphere of action as in the days when he was with his old friends at Guy's. We express our appreciation of the man, and our sincerest sympathy to his relations and friends.

ALSO we have to record the sad news that Private John Hampden Ross, 1/4 Devons, T.F., and L.D.S. (Eng.), has died of dysentery on active service in Mesopotamia.

WITH the issue of a Local Government circular, indicating the conditions under which

salvarsan or its approved substitutes will be supplied *free* for intravenous injection, it is suggested that the Medical Officer of Health should distribute the drugs, and have in his own hands the responsibility of decision as to the fitness of the applicant to administer these remedies. The necessary qualification is outlined as, firstly of course, registration, and secondly, certain very poorly defined conditions decidedly open to misrepresentation and abuse.

We see the whole scheme described as a compromise, and possibly in a community well inured to compromise it may work very well.

WE read of a doctor who, in applying for exemption of his chauffeur, stated that women chauffeurs could behave well, drive well, and look well, but that there was one fatal objection —they could never start the car. It seems that some would not agree with this sad experience, or else that when the self-starter fails they put their backs into it themselves. We have seen the lady chauffeur even at Guy's.

COMMENTING recently on the fact that a man, into whose death he was inquiring, had only one tooth, Dr. Waldo remarked that not long ago he made some observations as to the usefulness of artificial teeth, with the result that a gentleman who read his remarks gave £5,000 to St. Bartholomew's Hospital for the purpose of increasing the available supply. Dr. Waldo said he hoped that after the war some other benevolent person would extend similar help to Guy's.

GUY'S men will be interested to learn that, on his return from Malta and Salonika in July, Mr. C. J. Symonds, Consulting Surgeon to the Hospital, was appointed Consulting Surgeon to the Royal Victoria Hospital, Netley, the Associated Red Cross and Welsh Hospitals, and the affiliated institutions.

THE Annual Report of the Medical Defence Union, recently circulated, shows, in the table of cases undertaken, that libel and slander actions (on professional questions) are diminishing in the most gratifying manner, as also are cases of unqualified practice, impersonation and malpraxis. On the other hand, partnership disputes, arbitrations, and many matters arising out of the workings of the National Insurance Acts tend steadily to increase.

Notice.

Army Council Instruction.

WAR OFFICE,
22nd August, 1916.

1640.—Medical Students classified in Categories B and C. Transfer to Class W Army Reserve or to Class W (T.) T.F. Reserve.

1. Medical students now serving with the colours who have been duly registered as such in the books of the General Medical Council and who were at the time of enlistment actively engaged in medical studies, if not passed fit for general service (Category A) are to be relegated to Class W. Army Reserve, or Class W. (T.) T.F. Reserve in accordance with the procedure set out in A.C.I. 1174 of 1916.

2. G.OsC.-in-C. will take necessary steps to ascertain whether any medical students in the above class are serving in their command. In the event of any doubt arising as to whether a man is to be regarded as a medical student in accordance with para. 1, he should be required to produce a certificate from the Dean of the Faculty of the College where he was studying.

3. Men thus relegated to the Reserve will be required to return to their professional studies and to enrol in an O.T.C. in accordance with the provisions of A.C.Is. 389 and 1188 of 1916.

4. Where a medical student is holding a commission, but is not fit for service overseas, a statement of the case should be forwarded by the G.O.C.in-C. Command for the consideration and decision of the Army Council.

By Command of the Army Council.

R. V. BRADE.

Obituary.

Lieut. LIONEL W. MOORE.
Killed in action.

Lieut. Moore, who was acting Captain of his company, was only 23 years of age last November. He was educated at Tewkesbury Grammar School and King's School, Worcester. Upon the completion of his school career he took up his studies for the medical profession, and was for 3½ years at Guy's Hospital before the outbreak of war, when he at once sought his country's service. For four years he was a member of the local company of Territorials, and whilst in London he joined the medical unit of the London University O.T.C. The Commanding Officer of the latter recommended him for immediate commissioned rank, but he enlisted as a private in his county's regiment, and was quickly promoted to a second lieutenancy. He went to the Front in March, 1915, and had served with his regiment until the time of his death. As a youth he was assistant scoutmaster of the 1st Tewkesbury Troop of the B.P. Scouts.

The magnificent testimony of his brother officers, from many of whom Mr. and Mrs. Moore have received letters of sympathy, is a reflection of his character as it was known by his friends. A splendid officer, a fine young fellow with an unblemished record, he was one of the best of the many thousands of the flower of the race who have given their all for their country, King, and people.

Mr. and Mrs. Moore received a letter, dated 29th August, from the Chaplain, who says:—"I buried your splendid soldier this morning at 4 a.m. in the very trench which he and his men took magnificently on Sunday night. It has made us all feel very sad indeed, and our hearts go out to you and yours. I watched him and his company; they went over the parapet as if they were on parade, and great execution was inflicted, and the trench was taken and held. We all held the highest respect for your boy, and it was only last week the Colonel himself told me how much he relied and believed in him."

The Colonel of the Battalion wrote that unfortunately he was in hospital, and was unable to be in the action, but his brother wrote him that Lieut. Moore was leading his Company splendidly, and they took the trench, which was heavily manned by the enemy's best troops. He was a worthy successor to his splendid brother.

A brother officer wrote: "He was the most unselfish man I ever met, and every officer in the regiment would say the same. With an extraordinary gentleness and unselfishness he combined the fearlessness of his brother. One always felt better for being with him in the trench, or on any business unpleasant or dangerous.

Pte. Vosper, the deceased officer's servant, also wrote to Mr. and Mrs. Moore a very touching tribute.

Lieut. Moore was last home on leave in June.

Change of Address.

2nd Lieut. J. W. Featherstone, Worcester Yeomanry, c/o Base P.O., Alexandria, E.E.F.

L. M. Wheeler, Clovelly Road, Bideford, Devon.

Lieut. C. W. W. Baxter, I.M.S., c/o Grindlay & Co., Bombay. Home address: "Rosevine," Portscutho, Cornwall.

Pte. J. A. Bouic, 7886 D Company, No. 3 Hut, Artists' Rifles, Gidea Park, Essex.

Surg. Prob. C. R. Cade, H.M.S. *Dido*, additional H.M.S. *Beaver*, c/o G.P.O.

2nd Lieut. J. E. H. Winston, 4th Yorks. Regt., Hackney Wick Camp, Redcar, Yorks.

Lieut. L. Muir-Smith, R.A.M.C., 32nd Field Ambulance, Salonika.

2nd Lieut. V. Drew. D.C.L.I., 44th Training Res. Battn. (11th Devons), Worgret Camp, Wareham, Dorset.

Capt. J. H. Jonas, R.A.M.C., from H.M.H.S. *St. David*, to H.M.H.S. *Nevasa*, c/o G.P.O.

Capt. Donald Clewer, attached R.A.M.C., from North Camp, Seaford, to 2/2nd London Casualty Clearing Station, 4th Army, B.E.F., France.

The Drugged Sweet Scare.

G.H.F.G.'s article is trenchant, truthful, and delightful, up to a point. Had the author rested content with scarifying the "white slave" scare all would be well, but he was tempted to state airily the real facts. Incidentally it is notorious that the chief "white slavers"—if that be a proper description—were found to be women, apart from the individual "bully."

It is, however, in his easy pronouncement of the "real causes of prostitution" that his foot slips. He states that it is not due to "a glib seducer, pockets full of chloroform" (I have always wondered *what* they put in the beer—that hoary, hopeless excuse), "drugged sweets and bogus certificates," but to "underpaying employers" and "virtuous churchwardens deriving dividends from the underpayment of women"; and the "simple logical plea that she did it because she was hungry" apparently satisfies him completely, although this problem of "why" has perplexed countless earnest minds, and does still. He finishes by denouncing conventional shams and hypocrisy.

Surely this is a conventional sham if ever there was one! Personal observation, enquiry, and the experience of married men and women would surely convince him that a "glib seducer," often aided by a promise of marriage, often, too, with the aid of that famous moral solvent—a drink—is the initial step in countless cases; that the servant class illegitimacies (a very large one) arises from sheer ignorance, feeblemindedness, inability to refuse a lover, etc., but never from poverty and never from choice.

He cannot be entirely ignorant that the vast majority of the fallen in their earlier prosperous days would not, and will not give up the life, however they may lie, when finally in the gutter.

In truth the picture he unwittingly has drawn of naturally virtuous women driven to vice by economic necessity has no backing of fact. I knew the theory as a suffragette stock-in-trade ante bellum, but I did not think G.H.F.G., whose papers I have often enjoyed, would have failed to appreciate the value of an assertion as against the facts.

There is another side to the question; broadly speaking, it is true that few women are accosted, and practically none molested, in this vast city, unless they provoke attention by dress or demeanour, while to my knowledge young cadets are literally pestered when they go out of camp. The biological fact (should I say, in his elegant but superior phrase, "the observation of a trained mind") is that of all emotions, etc., instincts are the most powerful. Sex instinct is a very powerful one. The lower instincts can only be feebly restrained by the higher. Morality—if you will—or religious instinct, as I prefer to call it. Compare, Panic controlled by Reason.

Fully sharing his horror of conventional shams, remains a

QUONDAM EDITOR.

Papers by Guy's Men.

Herbert French, M.D., L.R.C.P.: Syphilis of the cardio-vascular system.—*The Clinical Journal*, Sept. 6th, 1916.

F. E. Fremantle, F.R.C.S. Eng., F.R.C.P. Lond., D.P.H.: The ground-level latrine.—*The Lancet*, Sept. 16th, 1916.

Roll of Honour.

Killed.

Capt. Dudley George Pearce, R.A.M.C., "The Buffs."
Capt. Sefton Miller, R.A.M.C.

Wounded.

Capt. W. K. Fry, R.A.M.C.
Capt. W. E. Wallis, R.A.M.C.

Three Cases of Head Injury.

1. H. R., æt. 24, was admitted on August 24th, 1915, for concussion. He had fallen on to the back of his head. There were no external signs of violence. He presented the usual signs of severe concussion. Within a few hours he became semi-comatose and extremely violent and noisy, having to be strapped down in bed in the strong room. His breathing became stertorous, but there were no signs of paralysis, or any localising signs indicative of any local brain injury. He had incontinence of urine and fæces. He never became completely comatose, but was continually violent and noisy. His pulse rose to 130. He was lumbar punctured, blood-stained fluid under pressure being obtained. The effect of the lumbar puncture was to make him less noisy and violent and to bring his pulse-rate down. He was lumbar punctured whenever his pulse rose to 120 or over, blood-stained cerebro-spinal fluid being obtained each time, and there was the same beneficial result each time—in fact, after the second puncture he became sufficiently conscious to ask for a drink. Fluids were taken fairly well. Haustus paraldehyde had the best effect of all hypnotics; ʒi. every four hours for three doses quietened him, after which he was much improved. He became rather "bubbly" from retained secretions, and this was treated with atropine.

He was discharged to a convalescent home on September 22nd. His mental condition was quite rational, but he was dull, and sometimes took a long time to answer questions. His temper was good; he kept very much to himself in the ward and was very quiet.

Some weeks later he returned from the convalescent home not feeling well and complaining of weakness in his left arm, which had developed since his discharge. He looked very ill, with an anxious expression in his face. He complained of those weird pains in the head and body that always seem the sequelæ of bad concussions to the nervous system. He was sent to Nerve Out-Patients.

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2. W. D., æt. 48, was admitted for a fractured base, on August 16th, 1915. He was found unconscious in the street. A relative gave an obscure history of the man having been injured in a fight some days previously, and having had fits on several occasions since.

The patient was conscious when seen; he seemed very worried about himself. He would start to answer questions, but was unable to continue, tailing off into a murmur accompanied by an irritable gesture.

Dried blood was found in the left external auditory meatus. He had a bruised right eye and nose, the bruises being old. Plantar reflexes were normal. He also had an exaggerated right knee jerk, his pupils being equal and just reacting to light.

On the evening of the day of admission, about 9.0 p.m., he had a fit, consisting of clonic convulsions of the right arm and leg and right side of the face. His eyes were deviated to the left.

His pulse, 60 on admission, rose to 84, but throughout his illness always remained between 70 and 80 and occasionally went up to 88. His temperature remained sub-normal, except that on the 17th it went up to 100·8°. After the fit he remained in a semi-comatose condition. His right knee jerk was now very exaggerated. Plantar reflexes extensor remarkably well marked on the right side. Right arm was paralysed, while there was twitching of the right side of the mouth.

On the 17th his pulse went up to 124, but steadily came down and remained at the level mentioned above. He continued the fits up to the 19th, sometimes having a series of them. On the 18th some of the convulsions involved the left leg more than the right. No lumbar

puncture was done. Wassermann reaction was negative. He steadily got better and gradually got his speech back. He was kept on fluids and his bowels kept well opened. He was kept on a low diet until his aphasia was completely better.

When quite conscious and able to speak he would sometimes act in an extraordinary fashion. He would lean out of bed and chase bits of "fluff" about the floor under and around his bed. He would refuse food altogether, and make unfounded charges with regard to his treatment. He was surly and rude. He was a soldier, and was always worrying about his pay, and wished for his discharge. He often took a long time to answer questions, and frequently did not appear to understand what was said to him.

He eventually made a complete recovery. On discharge his mental condition, temper and general behaviour was that of a perfectly normal human being; in fact, his temper and conduct became quite good.

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3. Unfortunately the next case is one of those of which I have not got any notes. It was a case of middle meningeal hæmorrhage.

The patient was a middle-aged man. He had fallen some considerable height on to his head. He was very dazed when seen in the surgery, but was perfectly conscious and could tell us all about the accident. His pulse was good but slow, he had no paralyses, the pupils reacted to light normally and were equal. After his rest on the couch he was feeling much better. About an inch above and slightly behind the right external angular process of the frontal bone there was a small scalp wound. On probing this, bare bone was felt, and an irregularity in it could be felt, as if the probe in being moved along slipped over the edge of a crack and into the crack, which could be much better felt than described. He was admitted into the ward and put on the routine half-hourly pulse rate for all cases of head injury.

The man had not been in the ward much more than half an hour when he became absolutely comatose, with stertorous breathing, dilated fixed pupils, and the left side of the face, left arm and left leg were paralysed. He was taken to the theatre, and Mr. Rowlands operated. On exposing the skull over the right temporal region, it was seen to be badly smashed, with several cracks radiating from it; one of these, a large one, extended backwards and slightly downwards across the direction of the anterior branch of the middle meningeal artery. The hole in the skull was quickly enlarged; on doing this it was seen that there was a large blood clot inside, so large that one wondered if there was any room left for the right hemisphere of the brain. The clot was scooped out, but the hæmorrhage was so severe and the patient's condition so bad, that there was not time to search for the artery in that mass of blood welling up from inside the skull. The wound was very tightly packed and stitched up, and a very tight bandage applied.

Next morning the patient was conscious and was able to move his fingers of the left hand a little. A few days later the packing was very carefully and gently removed. There was rather much hæmorrhage, so the wound was tightly packed again. A few hours later he again became absolutely unconscious like he was before. He was taken to the theatre and the hole in the skull enlarged. The bleeding was less this time, and it was seen that the hemisphere of the brain had regained to a slight extent its normal size. The anterior branch of the middle meningeal artery was tied in two places. There was still considerable hæmorrhage from the direction of the anterior part of the longitudinal sinus. A tight packing was put in this direction. The wound was

then stitched, leaving an opening for the packing. The external carotid artery was then tied.

The man regained consciousness and his paralysis completely recovered. The packing was very carefully taken out after about a week. Later the sinus left by the packing discharged an astonishing amount of pus. Later still he developed erysipelas in the wound. This cleared up all right, but the wound continued to discharge pus. An operation was performed to try and find out the cause of this long continued suppuration. Several sequestra were found and removed.

Finally he was discharged to a convalescent home after having been in hospital about six months. The wound was improving but still discharged a considerable amount of pus.

J. F. H. S.

A Landsman with the Fleet.

III. ON LEAVE.

For weeks little else has has been talked of in the mess. For the last ten days in the intervals of meals the ward room table has been a litter of Bradshaws and holiday guides. The ship's company has been mustered and harangued by the captain on the penalties attached to leave breaking, by myself on the perils which beset the matelot in a strange city. And now they have been mustered for the last time, the first leave party exceeding joyful, the second leave party, who have to stop on board for the first half of leave, heavy hearted and morose. Very smart and trim do they look in their number ones, gold badges replacing the red cotton guns, torpedoes, propellers, anchors, etc., which indicate their rank and branch in the service on the work-a-day attire. The men have to buy their own clothes and gold bars and badges would, so says a paternal government, put too heavy a strain in the lower deck exchequer. Not that the 'and fails to appreciate smartness and a little finery (King's Regulations permitting). Observe closely his trousers, those wondrous bell bottoms are in their ample folds a sign of lavish means, their size in direct ratio to the wearer's claim to be considered *dernier cri*.

Notice, too, that series of parallel creases, some eighteen inches apart, which run horizontally up the trouser leg. Just as the "nib" on the beach prides himself on a vertical crease, so does the mathematical exactitude of these show the meticulous care with which the trousers have been folded and put away, wrapped in a silk handkerchief, in the matelot's kit bag. In the spacious days before the war, many were the extras which were allowed to be added to the regulation kit. In all the large seaport towns Jew slop tailors would come aboard selling villanous suits of shoddy mufti, wherein the sailor, transformed from a cleanly, business-like fighting man, to a slouching, ill-hung lounger, would disport himself in haunts better imagined than described. Shiny broadcloth trousers, terminating in "super-bells," would replace the regulation Navy serge, silk ribbons of many shades and colours replaced the simple blue tape in tying the "silk" in position. The jersey was even lined with red plush, so that in a saloon bar the matelot, ostentatious, by searching in his trousers pockets for money, would display the inner lining with a negligent air.

Now, happily, the uniform is perforce worn simple and unadorned, and certainly in shore-going rig, he who does not find it admirable in every way must be hard to please.

The spotless white flannels, the blue jean collars whose surface must never be marred by the use of starch, the gleaming cap covers, snowy as pipeclay and elbow grease can make them, the "silk," black and shiny as a raven's

wing—it is a costume that makes one sigh in vain at civilian ugliness. Even the cap ribbons have been changed, a simple H.M.S. replacing the name of the ship worn on service.

The last of the crew have been given their railway passes by the coxswain, and have departed their several ways, happy as a pack of schoolboys.

Farewells have been said, a final look taken round the chaos of one's cabin, lest, perchance, some essential should have been forgotten. (Heavens as though it mattered!). "You niddy doctors have all the luck!" grumbles one of the left-behinds, for I get all the leave; then a long climb up a ladder black with the grime of ages, a scramble across a greasy oiler, a guarded descent down a perilously sloping gangway, and once again one's feet tread on good hard British soil. I could, if you would stand it, expatiate for hours on the thrill of once more walking when and where you will, the pleasure merely in boarding a tram or catching a train; in fact, in any of the familiar and commonplace acts of existence.

To go out for the first time after a long and tedious illness is to experience in some measure this peculiar joy, a convict after release from a lengthy spell of "time" must feel it *par excellence*. In the language of the cocoa advertisements, it must be tasted to be described.

For long enough it has been a journalistic commonplace to say that the war has led to the revival of various arts and customs fallen into desuetude. The art of letter writing and the rehabilitation of an early age for marriage are familiar examples. To my mind as significant a feature as any is the new zest that changed conditions have given to all kinds of travel. The transport and despatch of troops, the consequent change of domicile of tens of thousands of those very classes who in pre-war days travelled the least of all, have given our busy railway centres an entirely new character Travelling as in the days of the stage coach, or, say, of the Napoleonic wars, has assumed once again, some of the trappings of romance. The limitless boredom of more pacific moments is no more—the old gentleman ensconced behind his *Daily Telegraph*, whose proximity you avoided if you were wise, knowing in advance the Nestor-like sapience that would flow from those hoary lips, what time the newsheet was laid aside—the window shutting pests, the host of ill-nurtured, inconsiderate bores, that made of one's journeyings a time of wretchedness. But the trenches do not engender a morbid horror of fresh air, and tales of the military life, even if they lack a certain freshness, are infinitely preferable to an enumeration of the iniquities of Mr. Lloyd George. Indeed, it is always with a certain expectancy nowadays that I set forth upon a long railway journey Say what you will, there is something indefinably thrilling in sitting with men who have looked death in the face not once but many times, in hearing from their casual talk of escapes, attacks, last hopes, the commonplaces of military hardship such as leave a peaceful age silent and aghast with wonder. It is often not so much the matter as the manner of these impromptu Odysses that give them their strange epic quality. The simplicity of the narration, the studious avoidance of any tone but the *banal*, make many of these stories rank as high as the work of Tolstoi. Then again there are the eternal tragi-comedies of farewell, enacted at every station with bewildering sameness and regularity. Saying goodbye is never an Englishman's *forte*, the repression of emotion has too long been a point of national honour to allow of the facile *épanchements* of the Continental leavetaking. It is at once droll and pathetic, the women folk pitiful in efforts to be "brave," which would hardly deceive an unborn babe, the men torn between a real and natural feeling and a laudable desire to live up to the

uniform they have just donned. Worst of all is the train that will *not* start. All has been said long since and in their anguish the talk seems to turn inevitably to flannel underclothing. "Well, you will *promise* me to wear them, won't you dear? And if you should feel cold, don't hesitate to write for more. And you *will* be careful and duck when you hear the bullets—" Fortunately, however, the guard blows his whistle just as this stage in the conversation is reached, and the victim sinks back into his corner with a sigh of relief, blushing like a red, red rose. And for the next half-hour or so he carefully avoids catching your eye.

Other minor amusements include the novel and exciting round game of "Hunt the Duchess," and the equally diverting "*Cherchez la Bass*," a game, I understand, which has an enormous vogue across the Channel. For the former, all that is required is half a dozen copies of the illustrated weeklies, a large railway station, and a soldiers' canteen. The competitors, armed with copies of the *Sphere*, *Tatler*, etc., advance in open order upon the canteen, and having dug themselves in, proceed to compare the fair damsels dispensing coffee and sausage and mashed with the photographs of the members of the peerage in their papers. The first one to detect a Duchess scores ten points, a Marchioness, eight, and so on, an Honourable counting but one. The latter pastime has been introduced to enliven the tedious business of outwitting the regulations of the local licensing boards. Each one of these apparently adjusts the times for opening the refreshment bars in such a way that they close automatically as a train is signalled to enter the station. The game is one requiring great tact and presence of mind. Every player who secures a bottle of Bass or stout, with which to assist nature in her task of assimilating the mortal remains of the cross-country champion supplied in the Company's luncheon-baskets, scores ten points. After dark, one has the "Is-this-my-station" plagues, and the blind-fidgetters, but these species are too well known to need description.

* * * *

With the possible exception of Paris there is, I suppose, no city in the world which possesses so peculiarly the faculty of making its citizens feel an integral part of itself as does London. Your man from the Midlands may prate of Municipal Enterprise, the Corporation Art Gallery, the cheapness of electric lighting, the superlative excellence of the tramway system. But the Londoner's affection for his city goes deeper than things material, it recks little, as it may well do, of bodily comforts and corporate enterprise. For most it is some subtle, almost subconscious, stimulant of the senses; a chance odour indefinably associated with a long past pleasure, the haunting recollection of a ray of sunlight shining upon an empty square, the incidence of some familiar clamour, which serves as summons for the hosts of memory. Perhaps it is merely the keen, animal delight of plunging once again into the throng of turbulent humanity, or that fear of solitude which haunts most of us against our will. A Cockney, whom circumstances had forced to spend many years in the tropics, once told me that the first time on his return that he heard the roar of traffic over London Bridge, he could not speak for the lump in his throat. I, for one, can well believe it.

For myself I always experience a strange sense of familiarity and yet strangeness, as of scanning the face of a friend one knew intimately years ago. In these days of darkened streets I hurry, as if for protection, to the nearest tube station, where reassured once more, I stop to watch the faces of these crowds of people, seemingly so unappreciative of the profound privilege of living in London. Tiring of this, and in their turn, I study the advertisements, noting jealously fresh faces, comparing them in my

mind's eye, with those that preceded them, judging some a little better, most not so good. These two small children here, tasting the tin of condensed milk are not so good as the damsel offering you a spoonful, leaning out of a casement embowered in roses which was on all the hoardings a twelvemonth ago. Idly I wonder what has become of her. Poor thing, how spattered she used to get with London mud! A murmur of voices attracts my attention. Surrounded by a group of women, puffed out with conscious manhood, stands a matelot. Looking again I recognise him as an ordinary seaman from the ship, a mild and inoffensive little man, rather looked down on by his comrades as being a "Crystal Palace sailor" (*i.e.* one joined for the duration of war). After a talk I gave the ship's company on hygiene, he would come every few days and show me his spots. Now, encircled by adoring females, he might be a figure from a norse saga. "Good-bye, sir" he says as he passes me; for some reason or other I am absurdly pleased.

Speeding southward in the tube, I predict to myself the coloured tiling of each station, childishly happy when I have guessed aright; even in negotiating two complicated changes I am delighted to see I have not forgotten the way. "Good evening, sir" says the old gentleman who clips my ticket at Victoria, and, in being thus recognised, I feel that my cup of happiness is full.

* * * *

We are back again. In half an hour we are due out of dock; in another two we shall be at sea again. In the wardroom there is a depression that is almost palpable. The engineer is morose, the captain monosyllabic. The sub. in a laudable effort to cure our melancholy, starts the gramophone. It is a sweet and sentimental tune, and most of us have heard it in the leave. Just now its memories are too poignant. "Turn the damned thing off," says the first 'tenant, and goes up on deck. I follow him, the atmosphere of the ward room is suicidal. A light breeze is blowing and the evening sky is as beautiful as a dove's wing. Little flecks of cirrhus scud across a great expanse of palest blue, the sun has tinged their undersurfaces with a brush dipped in pure gold. The clamour and hideousness of a great industrial river is around us. The air is rent with the din of hammers and pneumatic drills. Outside the dock the tide surges up, a noisome flood charged with impurities that kill all animal life. Massive structures cut the sky line into a thousand pieces, floating cranes with delicate girders like antennæ, the thin wires of overhead railways, the great cones of blast furnaces. At their feet men and women begrimed into the universal monotone scurry like frightened ants. A fœted stench arises from the slowly filling dock in which we lie. I glance at my watch. It is nearly the half-hour. Soon we shall be threading our way down the narrow traffic crowded stream. I am glad. One needs the great open spaces of the sea to purge the memory of this pollution.

G. H. F. G.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Chicken-Pox and Shingles.

DEAR SIR,—A few weeks ago I saw a man, aged 45 years, with herpes zoster and a rash indistinguishable from chicken-pox, both out at the same time.

The illness began with severe pain around the side; an extensive rash of herpes zoster came out next day, with the usual distribution along the course of an intercostal nerve. On the fourth day a crop of typical chicken-pox spots had come out, some papules, but many already in the vesicular stage. They were distributed over the trunk and limbs and also in the mouth and over the face and scalp. Both diseases ran a normal course.

I could not trace where the chicken-pox infection had come from. This patient had no children, and his wife, who had suffered from chicken-pox as a child, remained quite well. He himself had not had chicken-pox before.

There would seem to be no doubt about the relation between these two conditions, but although the relation was pointed out some years ago, most of us must

have seen many cases of herpes and many others of chicken-pox without any evidence which appeared to connect them. I think one or two of your correspondents, recently, have rather over-estimated the association.

I suppose a case, such as the one I have mentioned above, might be regarded as a case of chicken-pox, with herpes Zoster as a prodromal or early associated complication. Is it possible that some of the cases of herpes Zoster, which appear to give rise to, or to follow from, infection of chicken-pox, are really anomalous attacks of chicken-pox, possibly in many cases second attacks, in which the typical spots are absent?

—Yours truly, HUGH BARBER.

Derby,
27th August, 1916.

DEAR SIR,—Judging by Dr. A. Read Wilson's letter published in the GUY'S HOSPITAL GAZETTE, September 9th, 1916, he does not appear to have read the long series of communications published by the GUY'S HOSPITAL GAZETTE, and sent in by Guy's men, giving accounts of cases similar to that mentioned by me. Also, in reply to Dr. A. Read Wilson I should like to say that chicken-pox in adults is often extremely painful, as is herpes; but in children both complaints are almost free from pain.

Moreover, some of your previous communications have given cases of herpes appearing on persons who have been in contact with chicken-pox, the converse of my case, and for which Dr. A. Read Wilson asks.

—Yours truly, HERBERT CARDIN.

Stock, Ingatestone,
September 10th, 1916.

The Metric System.

DEAR SIR,—In view of the movement on foot at the present moment to introduce the more scientific metric system into general use, both in medical and in other professions and trades, I venture to suggest that if physicians and house-officers should make it a fixed rule to do all prescription writing, etc., in the metric system, they would materially assist and encourage students to make themselves proficient in this almost universally used system. After the war a tremendous commercial struggle is sure to ensue between the various nations, and it behoves this country to take advantage of every little item which may help her to retain that commercial superiority from which she has been so nearly ousted before the war by superior foreign methods. The metric system is standard in the new "British Pharmacopœia," but the old system is still allowed for examination, and this simply means that nobody is going to trouble to become conversant with a system which is less familiar. It takes some time to become well accustomed to "think" in new measures and weights, but the sooner we are forced to do so, the sooner will we rid ourselves of the obsolete and unscientific Imperial system, which can claim popularity as its only advantage. Thanking you for publication,—Yours, etc., J. V. M.

Rough Notes on Anæsthetics.

DEAR SIR,—In reference to above it may interest some of your readers to know that Mr. Tom Bird has given chloroform for me for the last forty years and without any approach to an accident. He is still giving it for me at the County of London War Hospital, and only this afternoon in four cases which averaged an hour each. If I had to take an anæsthetic myself it would be chloroform, and I should ask Tom Bird to administer it, but I would not have it given by anybody.

For a good rough and tumble anæsthetic commend me to A.C.E., or, as it is now, C.E. A.C.E. was the anæsthetic almost invariably given for me in the Eye Wards at Guy's from the time it was first introduced till I left the hospital ten years ago. It was given for all the first 25 years or thereabouts by the dressers, many of whom had had no experience before, and I never had a single death and very few cases which caused me anxiety, but then I was always at the right end of the patient and could see what was going on, and I have often knocked the inhaler out of a dresser's hand when I saw that he was not attending to what he was doing or that the patient was not taking it nicely.

I never had but one death from an anæsthetic, and that was from a compound called methylene ether. The bottle in which it was contained had a label on it setting forth that it was a *perfectly safe anæsthetic*, and I heard afterwards that it had caused two other deaths in the same week. I do not think it was ever used again. I must have been singularly lucky, for that is the only fatal case I have seen in my life, and my experience extends from about 1867, and I should be afraid to say how many times I have given anæsthetics myself or had them given for me; the administrations must amount to many thousands.

In your same issue (September 9th) there is an article on hæmothorax which has caused me much thought and shows how much the profession has become influenced by the War Office custom of using initials; the writer says he gave injections of I.M.H. and I.A.H. (in capital letters). Now that took three great minds about half the time that we were employed on an operation that took an hour, to make out what the initials represented. At the end of that half hour one of the possessors of one of the great minds (not myself) decided that I.M.H. meant Inject. Morph. Hypoderm., and the I.A.H., Inject. Atrop. Hypoderm., and I think the possessor of the great mind was correct.—Yours truly,

Sept. 14th, 1916. CHARLES HIGGENS.

Aspiration in Hepatic Abscess.

DEAR SIR,—Capt. Reinhold in his letter in your issue of September 9th calls attention to the re-introduction of aspiration in the treatment of hepatic abscess following amœbic dysentery. In confirmation of his experience the following may interest your readers.

In Malta I saw in consultation with various medical officers men with enlarged livers, where the question

of operation arose. It was most satisfactory how the condition improved under emetine, so that few came to operation. In one instance to which I was called by Col. A. Garrod, a young soldier had high temperature, a pericardial rub with displaced heart, and was very ill. A hepatic abscess had been suspected, and it was thought rupture into the pericardium had occurred. Physical signs could not localise the abscess, and the question before us at the moment was in which direction lay the smaller risk, to open the pericardium or the abdomen. In the end we postponed, and passed the emetine. All urgent symptoms subsided; the heart, however, remained displaced, and there ensued slight left pleural effusion.

Capt. King, who had seen eight cases recorded in China after aspiration preceded by emetine, advised this line of treatment. Being uncertain as to the position of the abscess, we decided to explore the right lobe, and failing, to examine the left through an abdominal incision as less dangerous than exploration.

A large abscess was found in the left lobe, adherent to the diaphragm. The under surface was hard and irregular like that found in an old hydatid. The needle was driven through with some difficulty, and nearly a pint of pus of a thick, yellow colour re-removed. A rubber drain was inserted down to the site of puncture in case of any re-accumulation. The progress was most satisfactory. The heart returned very soon to the normal position, and no recurrence. took place.

This brief note I write to confirm the value of aspiration in these cases where, under emetine, the pyrexia and other symptoms have subsided. The method of exploring the liver through an incision to ascertain the presence and position of an abscess, has, with aspiration as an effective treatment, a new value.

—Yours faithfully, CHARTERS J. SYMONDS,
R. V. H., Netley Abbey, Col. A.M.S.
September 17th, 1916.

SIR,—An article by Mr. A. Withers Green appeared in your last issue entitled "Rough Notes on Anæsthetics." An utterly wrong impression in one important particular is conveyed by it. We, who are mainly responsible for the teaching of anæsthetics at Guy's feel it necessary to insist on the fact that chloroform is much more dangerous than ether. It follows that the administrator who uses chloroform in preference to ether except in the comparatively few cases where the latter is contra-indicated, ought to be thoroughly aware of the responsibility which he incurs in thus subjecting his patient to an unnecessary risk.—

We are, etc., GEORGE ROWELL.
C. J. OGLE.
Guy's Hospital, H. M. PAGE.
September 19th, 1916. F. E. SHIPWAY.

DEAR SIR,—I should be so grateful if you would kindly allow me to express through the medium of your columns my gratitude to the Guy's men who have so kindly offered me their congratulations on the occasion of my marriage, and have sent me such a beautiful wedding present. I highly appreciate, and am much touched by, such an expression of good wishes.

—I remain, dear Sir, yours sincerely,

Dalmally Hotel, W. H. TRETHOWAN.
Dalmally, Argyleshire,
19th September, 1916.

Appointments.

Medical School Appointments.

OCTOBER–DECEMBER, 1916.

Dressers or Clerks in Special Departments:—

a. Throat & Ear, Genito Urinary, Children.—Messrs. A. Bulleid, J. R. Cox, J. C. Gie, C. H. Laver.

c. Eye and Nervous System.—Messrs. J. A. Berry, O. St. L. Campion, L. Gill (Mr. Eason); E. H. Bryant, W. R. G. Hearnden (Mr. Ormond).

Obstetric Dressers and Externs.—Messrs. J. J. Conybeare, J. W. H. Grice, S. T. Wong (Mr. Bellingham-Smith); C. G. Coombs, E. C. Hinde, S. M. M. Jabir, (Mr. Chapple).

Extern (October).—E. F. Deacon.

Surgeons' Dressers.—Messrs. N. Kamchorn, G. Meadows (Sir Arbuthnot Lane); F. Caldecott, G. A. S. Shacklock, R. C. W. Staley (Mr. Dunn); W. A. Flynn, A. Y. Massouda (Sir Alfred Fripp); C. W. W. Armstrong, T. Fernandez, O. Halstead (Mr. Steward).

Extension Medical Ward and Post-mortem Clerks.—Messrs. H. G. Burford, H. J. Leviseur, W. H. Steavenson (Dr. Hale White); A. R. Doyle, A. L. S. Payne, A. A. Osman, S. Woolf (Dr. Shaw); H. O. Long, F. W. Reitz, J. Victory (Dr. Fawcett); L. S. Debenham, W. H. Grace, H. Millett, A. G. N. Severn (Dr. Beddard).

Medical Ward Clerks (first three months). Messrs. G. R. Aspinwall, T. G. D. Bonar, W. H. Cellier, G. Hume, L. Lyne, G. F. Peters, R. S. Ralph, R. W. Warrick.

Assistant Surgeons' Dressers.—Messrs. H. F. G. Berncastle, W. Kilroe, G. V. Richards, W. Skelly, S. A. Withers (Mr. Fagge); F. K. Escritt, J. Joffe, R. D. Roberts, C. G. Siggs, J. E. van der Merwe (Mr. Rowlands); C. Gill-Carey, E. F. Kerby, E. H. L. LeClezio, A. R. Neckles, W. H. Simmons (Mr. Turner); C. L. Curle, W. Gover, C. Moffatt, G. M. Thomas, E. R. Webb (Mr. Hughes).

Surgical Ward Clerks.—Messrs. L. Lavine, H. W. Southgate.

Clinical Assistant (November, 1916—January, 1917).—Mr. M. C. Joynt ((to Dr. Hale White).

Royal Naval Volunteer Reserve.

C. R. Cade, Surg. Probationer, H.M.S. *Dido*, additional to H.M.S. *Beaver*.

Royal Army Medical Corps.

Lieut.-Col. E. M. Pilcher, D.S.O., R.A.M.C., to be Brevet-Colonel.

Temporary Captain F. S. Brereton to be temporary Major.

To be temporary Lieutenants:—E. Evans, D. C. Druitt, J. M. Jarvie, T. A. Matthews, J. Goss, A. Kinsey-Morgan, J. E. Barnes.

Special Reserve of Officers.

From the University of London Training Corps:—B. E. Jerwood and T. Wilson to be Lieutenants.

Temporary Lieut. A. R. McLachlan has relinquished his commission.

Macedonia in War-time.

Its Country and Inhabitants.

BY AN OFFICER IN THE R.A.M.C.

[With acknowledgments to *The Hospital*.]

Months have stretched into years since last I sent notes on Nature to *The Hospital*. Not that I have not seen much to amuse and interest me in the ways of birds and beasts in many fields of war, but distractions are frequent on active service; it is hard to settle to the task.

I am in Macedonia and north of Salonika; that much I may say without giving away the situation, or exposing myself to censorship. The camp is scattered widely about an undulating plain bounded by high hills bare of trees of any size, but in places densely wooded with scrub: chiefly oak and certain thorny bushes. The plain itself is bare and has scattered bushes and much bramble-covered waste amongst its cultivated patches. Farming is primitive. It is hardly the right word here. "Cultivation" is better, for though there are considerable flocks of sheep and goats and herds of cattle, these do not go with the cultivation, seemingly, but belong to a separate industry. The plough is light, of wood, shared with iron and drawn by heavy-bodied, thick-set, short-legged oxen, that seem well-kept and resemble in markings and colour Jersey cattle. Water buffaloes, not different from those used in India, are sometimes substituted, but these latter more often haul heavy wooden trains of the most primitive type and piled with enormous loads. The buffaloes also look well-kept. The Macedonian is good to his beast. Though his ideas are liberal as to the burden of an ass, and though he does not count his own weight any addition to the burden, yet the animals seem well-fed and comfortable. I have seen no active ill-treatment of beasts of burden, nor signs of untended galls and sores.

SLOVENLY CULTIVATION.

There are no hedges. The fields are demarked only by the line of furrow, except they be growing vines, then usually a low bank or a low bank with a slight ditch bounds them. Fig-trees grow in the vineyards amongst the grapes. The potential fertility of the country is great, but years of war and uncertainty do not conduce to careful farming. The cultivation is slovenly; the lands dirty; very little manure is used; the crops are very thin. Between the rough patches of crops is much waste land; some that shows no sign of former cultivation, other that bears marks of the plough.

The crops most conspicuous now (I write in August) are maize, melons, and pumpkins. The people are winnowing cereals on the threshing-floors. Rye, wheat, barley and millet are the chief crops. The corn is trodden by the ox, the ass, and other domestic animals, assisted by a woman sitting on a sort of sledge. The beasts drag the sledge along the threshing-floor across the straw, round and round, to and fro. The combined effect of their sharp hoofs and the crushing of the weight of the sledge forces the grain from the husk and breaks the straw into a rough chaff, which is fed to domestic animals. When a brisk breeze blows the people assemble on the threshing-floors and toss the result of the treading into the air with wooden forks of three or four prongs slightly spaded. The heavy grain falls at once to the floor, the dust is blown away on to the surrounding fields or houses or casual passers-by, the chaff leaps to leeward of the grain. Then the grain is shovelled into a large sieve and sorted into good and bad in separate heaps.

CHARACTERISTICS OF THE INHABITANTS.

The people are mixed in kind; Greeks, Turks, and Bulgars. Though they inhabit the same villages they do not intermarry, I am informed, nor do they indulge in racial quarrels. The dress is bright, dirty, and picturesque. Minor differences mark the races, but the common feature is very baggy-seated trousers and a voluminous shawl wound many times round the waist. Such women as are not suckling babies shortly expect to be doing so. As a people they are not lovely. Those that live or work in the river valleys or near the lakes show markedly in their pallid, anæmic complexion the devastating effects of ague.

Since 1912 there has been much shifting of population. The Turks largely left the land when it came under Greek government. The Turks also expelled from Thrace many Greek peasants who had their homes there. Great hardship resulted. The dispossessed Greeks lost their all, and came paupers into the land. They have been allowed to settle on the land left vacant by the Turks, but as they have neither capital, cattle, nor implements they live squalidly in ruinous Turkish houses and eke a scant living from stony hill-sides. An oldish man, fine of face and figure and wearing a dress that, though shabby, showed evidence of better quality than his fellows, attracted my attention in a certain

village through which I was riding with an interpreter. Because he was the first fine-looking Greek I had seen, I bade the interpreter question him. He told me that he came from Thrace, where he had been a rich man with wide fields and 8,000 sheep, but the Turks had taken all and turned him out of their land. "And how am I to work to get food now when I am an old man?" he ended his tale.

Letters from Old Guy's Men on Active Service.

DEAR SIR,—A request for some notes from us on active service has made me send this short letter. We appreciate so much getting our GAZETTE regularly, and realise the difficulties you must have in keeping the old paper going as splendidly as it does. I have been out here with heavy artillery for about 14 months, and we have been on all the most important points of the British front from Ypres to the Somme, and our guns have fought at Ypres, Armentieres, Vimy Ridge, Albert and Bray, but it has been reserved for the last two months for them to do their best work. We are in the centre of this big advance, and for over two months there has been little rest day or night. In the preliminary bombardment they were going continuously, and ever since, as we have pushed on, the artillery work has continued, shelling hostile batteries, barraging roads, smashing trenches, and rendering impassable support trenches and other communications.

The work of an M.O. under these very changed conditions consists of constructing dressing aid posts near the batteries, which, if not shell-proof, are at least proof against splinters. The ordinary routine of seeing the sick has to go on, and inspection of sanitary arrangements. A few weeks ago we were shelled out of our position, which was an old German trench which we had made habitable. Without any warning the enemy suddenly loosed off every available gun and howitzer on us, and for exactly ten minutes gave us "hurricane fire." About 500 shells arrived in that time, and it was the most terrible bombardment I had seen. About an hour later, when we were recovering and I was still dressing and attending to the wounded, the same performance was again repeated, and once more in an hour and a half's time. After this the place became too hot to live in, and we now occupy some splendid German dug-outs. They are very deep and safe, but terribly dark and airless, and simply alive with rats and fleas. They all have stairs going down even deeper still, and, of course, during the hottest fire they were quite safe down in them. The room we use as an office was very well furnished when the enemy occupied it. It contained electric light, tapestry on the walls, curtains and doors, glass windows, and upholstered arm-chairs.

I saw a wonderful underground German dressing station the other day. There was a large room about ten feet below ground with other rooms leading out of it a broad staircase leading down to a passage, out of which opened at least ten other roooms with beds in, and stacks of splints and dressings, and wonder of wonders, a white enamelled *bath with hot and cold water laid on.*

The scene at night is always wonderful—the whole sky alight, shells bursting, and the various S.O.S. rockets going up from both armies calling for help from the guns. It is a bit dull, living all day in the same old ruins, but letters and papers from home keep you happy. The definition of the war which someone gave, and which I quote from memory, is very true—"A time of great monotony punctuated by occasional periods of extreme terror."—I remain, yours truly,

G. F. HARDY
August 22nd, 1916. (Capt., R.A.M.C.).

DEAR SIR,—At last I am able to tell you where I am and what I am doing. I have been so very busy, owing to such a number of our officers going to the front, that I have scarcely had a minute to myself.

Since I last saw you I have been appointed Physical Training and Bayonet Fighting Officer for our battalion. I have also been commanding my Company, as well as supervising all the sports. You can guess I have been up to my neck in work. My regiment won the Championship Cup for training events at a Gymkhana held here last month. We have also done very well in other things, but having to send every available fit man out makes a very big difference when one is arranging things. As soon as we get settled, the men are sent to France, and we have to start all over again.

I was supposed to have taken over the duties of Brigade Physical Training and Bayonet Fighting yesterday, but, owing to an outbreak of scarlet fever, it has been postponed till August 26th. I am now busy trying to get about 120 recruits into shape, but it is a very slow job. Route marches play steam with our men in this hot weather. We come back soaked with sweat, but after a dip in the sea and a change of things we are fit for another march.

Redcar is a very quiet place compared with Scarborough, but the sands are really excellent. There is no style about the place, and nothing to be compared with our late headquarters.

How is everybody at Guy's? I expect you are very busy, as no doubt a lot more have joined up. With the best of wishes,—I remain, yours very sincerely,

J. H. E. WINSTON,
15th Yorkshire Reg., 2nd Lieut.
Hackney Wick, Redcar.
August 13th, 1916.

Some Take-in Cases.

THE following are a few notes on some Take-in Cases that I had during six months House-Surgeon to Mr. Dunn. I must apologise for the scantiness of some of the accounts, but unfortunately I have not notes on all the cases or any clinical report at hand, and I have, therefore, had to depend on memory for some of them.

Pneumococcal Peritonitis.—A girl, aged 11 years, was admitted for general peritonitis. About a week before admission she was seized with sudden abdominal pain accompanied by severe vomiting and diarrhœa. After three days the diarrhœa got better, but recurred a few days later. There was no history of rigors. She rapidly became extremely ill and emaciated, and developed a noisy delirium. The vomiting became so severe that scarcely any food was kept down at all.

On admission she was extremely ill and very emaciated. She looked profoundly toxic. She had a typical meningitic cry. She recognised her mother, and sometimes understood what was said to her. Temperature 103° in the axilla. The pulse was weak and running and so rapid that it was impossible sometimes to count it. The tongue was dry and coated with a thick brown fur. The abdomen was distended, tender all over, but not rigid, free fluid was easily demonstrated. Rectal examination was negative except for a ballooned rectum. She had some œdema at the bases of the lungs, but there were no definite signs of pneumonia. The heart sounds were normal, and there was no bruit or pericardial rub. There was no retraction of the head, no squint or nystagmus, and Kernig's sign was absent.

Dr. Cameron, who saw the patient, diagnosed pneumococcal septicæmia due to pneumococcal peritonitis. He did not advise operation. The patient became rapidly worse, and, owing to the maniacal state of her delirium, had to be transferred to the Strong Room. Practically no nourishment was taken, and it was impossible to give her rectal salines or dextrose owing to her extremely restless condition. I.M.H. gr. 1/12 was given to quieten her, but was useless. Nepenthe, m. viii., followed by a further I.M.H. gr. 1/12 a few hours later were also of no use. The following morning spasticity of the legs was noticed, and Kernig's sign was present. She died about twenty-four hours after admission.

At the post-mortem examination acute enteritis was found. The abdomen contained a large quantity of pus. On the liver and intestines there was a large quatity of "buttery lymph," as is seen on the pleura in a case of acute lobar pneumonia. The appendix, although congested in conjunction with the general enteritis, was otherwise normal, and was obviously not the cause of the peritonitis. As regards the other organs, there was slight pericarditis around the origin of the big vessels. No endocarditis; the heart muscle soft and pale. The lungs were congested and œdematous, but there was no pneumonia. The brain and meninges were healthy.

It appears that the peritoneum had been infected from the bowel, the damage to the coats of the intestine having been sufficiently severe to allow of the passage of the pneumococcus. This disease, according to Clifford Allbutt's System of Medicine, is commoner in children under 15 than in adults, and in females than in males to the extent of 73 per cent. of the total number of cases, while the appendix is the more frequent cause in adult patients. It it frequently secondary to pneumococcal infection elsewhere, as in the lungs, throat, or the middle ear, and is then a blood infection. According to the same authority, 21 cases were primarily in the peritoneum, while 19 were secondary to infection elsewhere, the commonest source of the infection of the peritoneum being extension from the intestine, as in this case. This authority states that out of 7,868 cases of lobar pneumonia only 22, or 0·3 per cent. of the whole, gave rise to peritonitis. There is no pathological support for the view that the genitalia may be the channel of infection leading to the preponderance of this form of peritonitis in the female over the male, although gonococcal peritonitis is contracted by direct extension from the Fallopian tubes and abdominal ostia, as is well known.

The question always arises as to whether one should operate or not. Such acute cases as this generally end fatally. It seems to be the opinion that it is better to allow the acute symptoms to subside, and to subsequently open and drain residual abscesses. It might be pointed out that the flaccid state of the abdominal wall is not infrequently seen in the later stages of peritonitis in which the abdomen becomes full of fluid.

Twisted Ovary in a girl of 7 years.—This girl gave a history of one or two days' abdominal pain and vomiting. She was very flushed; temperature 100°, pulse 104. Abdomen slightly rigid, more tender in the left iliac fossa than in the right. On rectal examination a tender lump could be felt in Douglas's pouch.

On a laparotomy being performed by the R.S.O. a twisted left ovary was found. The pedicle was twisted three times, and the ovary was rather larger than an adult normal ovary; it and the Fallopian tube were almost black in colour. There was a little clear, blood-stained fluid in the peritoneal cavity. The specimen was sent to the museum. The girl made a good recovery.

Portal Pyæmia due to Acute Suppurative Peritonitis following an Appendicular Abscess.—This was a girl of 17 who was admitted for general peritonitis, giving the usual history of acute abdominal pain and vomiting, and lasting over a period of four or five days. The abdomen was very rigid and tender, especially on

the right side. The pulse was very rapid, and she was in an obviously dangerous condition requiring immediate laparotomy. This was done, and a gangrenous appendix removed and drainage instituted. She improved for a few days, but then began to go downhill, and the wound did not drain well, necessitating further operation. The wound broke down, and profuse discharge continued. The temperature remained up and nausea, vomiting and hic-cough contined. She then developed rigors which became frequent and severe in nature. Sometimes she had two or three in an evening. The temperature frequently at such times rose to 105·6°; she went blue and livid and became almost pulseless and icy cold, in fact, the rigors were so alarming that she appeared in imminent danger of complete collapse. The bases were impaired to percussion, but no pus was found on exploring with a needle. The liver area became extremely tender. Suppurative pylephlebitis (portal pyæmia) was diagnosed. The rigors were treated with heat, saline infusion, hot drinks, brandy, and strychnine. She lingered on for several weeks, became extremely anæmic, jaundiced, and emaciated. The feet and legs became œdematous. The rigors stopped. She lingered on for many weeks, and near the end passed into the typhoid state.

At the post-mortem examination multiple abscesses were found in the liver. Acute nephritis and little abscesses were also found in the kidneys. There was no pericarditis or infective endocarditis; no empyema present or subdiaphragmatic abscess. This is a rare disease, appendicitis being its commonest cause, and even in these cases only occurs in 0·5 per cent. of all cases (Clifford Allbutt's System of Medicine). Another authority, however, gives 10 per cent. (Treves). It is a rare sequel to other diseases of the abdomen.

Ruptured Jejunum with recovery.—This was a case that Mr. R. P. Rowlands reported in the *Lancet,* February 26th, 1916. A young man received an unexpected blow in the abdomen, and was admitted into hospital twenty-four hours later. He was collapsed and had a mounting pulse rate. The tongue was dry, the abdomen extremely rigid and tender. A two inch rupture high up in the jejunum was successfully sutured, and he made a rapid and excellent recovery, although there was extensive peritonitis present at the time of the operation. The post-operative treatment was mainly that given to cases of gastro-jejunostomy, except that the bowels were opened by enemata instead of by purges for about the first two weeks.

There were also two or three interesting bone and joint cases. In one case in a child, the lower epiphysis of the radius formed a sequestrum, being completely separated, necrosed, soft and rotten. Another boy developed an acute suppurative arthritis of the knee-joint as the result of a slight accident in the playground at school. In spite of laying the joint freely open, he developed septicæmia and pyæmia. Suppurative pericarditis supervened. At the post-mortem little abscesses were found in the heart muscle, one bulged into the cavity of one of the ventricles and was on the point of bursting.

F. A. H. S.

Appointments.

Territorial Force, R.A.M.C.

Third Home Counties Field Ambulance: Captain S. Hughes from attached to Units other than Medical Units to be Captain.

Home Counties Field Ambulance: W. C. D. Maile to be Lieutenant.

London Field Ambulance: G. Thomson to be Lieutenant.

Indian Medical Service.

The Secretary of State for India has approved the appointments of C. A. L. Mayer and C. W. W. Baxter to Commissions as Lieutenants, I.M.S., bearing date August 1st.

Civil.

F. Barnes, M.B., M.S., F.R.C.S. Eng., has been appointed Honorary Surgeon to the General Hospital, Birmingham.

Births.

ATTWATER.—On August 17th, at Grosvenor House, Southampton, the wife of H. L. Attwater, M.A., M.C. Cantab., F,R.C,S. Eng., Temp. Capt. R.A.M.C., of a son,

PALMER.—At Marine Parade, Worthing, on August 29th, the wife of Albert Sydney Martin Palmer, M.A., M.D. Cantab., of a son.

KENT.—At Tongshan, North China, on Aug. 3rd, 1916, to Dr. and Mrs. Hugh Kent—a son.

Marriages.

BLIGHT—WIGFULL.—On September 6th, 1916, at St. Andrew's, Sharrow, by the Rev. E. Blackburn, Vicar of Cowick. brother-in-law of the bridegroom, William Lyne Blight, M.D., F.R.C.S., of Cardiff, to Clara Jane, daughter of Mr. Henry Wigfull and Mrs. Wigfull, of Chelsea House, Brincliffe, Sheffield.

TRETHOWAN—HICKSON.—On Saturday, September 9th, at Rosslyn Hill Chapel, Hampstead, William Henry Trethowan to Joan Durham, younger daughter of Mr. and Mrs. J. Godfrey Hickson, of 20, Ellerdale Road, Hampstead, and grand-daughter of the late Arthur Durham, Esq., F.R.C.S., of Guy's Hospital.

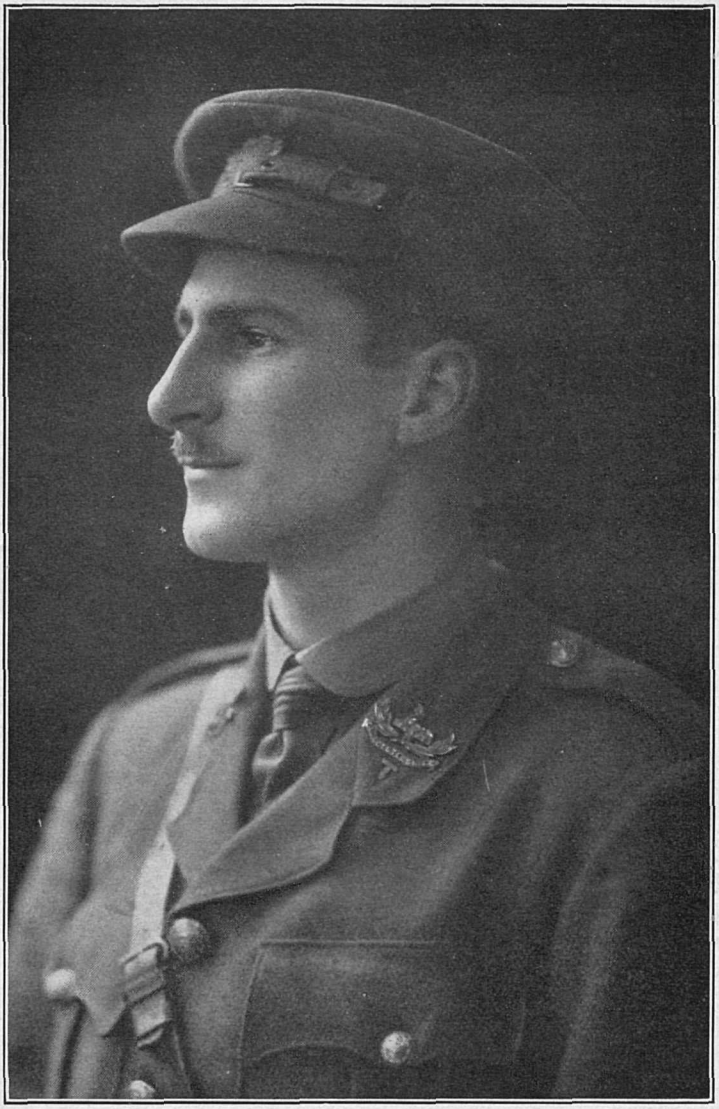
WINDEMER—GRIER.—On August 21st, at St. Goran, Cornwall, by the Rev. Upton Yonge, L. Duncan Windemer, L.D.S, R.C.S. Eng., of Tunbridge Wells, to Isabel C. A. Grier, elder daughter of C. W. Monroe Grier, M.B., of Polpier, Mevagissey.

Deaths.

HARRIS.—On Saturday, the 1st inst., at Paglesham, Essex, Edward Bernard Harris, M.R.C.S. Eng., L.R.C.P. Lond., L.S.A., late of Holy Innocents Road, Hornsey—aged 52.

MILLER.—Killed in action on September 8th, Capt. George Sefton Miller, R.A.M.C., F.R.C.S., aged 25 years.

F. A. K.
K. L. B.



Lieut. LIONEL W. MOORE, Gloucestershire Regiment.

Killed in action, August 28th, 1916.

GUY'S HOSPITAL GAZETTE.

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Passim.

IN announcing our Special Number we had necessarily to assume an apologetic mien, for the GAZETTE has been leading a truly hand to mouth existence, and at the time of writing hope was our only asset. There has, however, been a good response to our appeals, and, although we do not feel that the present number is in any sense a great achievement, there is some satisfaction to be derived from the facts that in all sections there is a decided increase, and that the long promised War Service Roll of Guy's Men has at last appeared in print. This list, as we would particularly point out, is still far from completion. Great efforts have been made to collect every scrap of information available, and the present result merits our praise for those concerned in the compilation. On the whole, the reply post cards have been extremely successful and proved the chief source of information. Curiously enough several have been returned unsigned, making the information supplied a little difficult to use, and as a consequence there must be several who will remember having posted to the Gazette Office, but fail to find their names on the Roll. To these, and to every Guy's Man engaged in War Service in any capacity, whose name does not appear on the official list, may we appeal that they send full particulars to the Manager at the Gazette Office. The cards have been sent to every man who could be traced, directly or indirectly, and to any who have escaped our efforts we would offer an apology and a request that they should write at once.

It is regrettable that the list was not in evidence long ago, but an appreciation of the difficulties and work involved will spare the Gazette Staff undue criticism.

ONCE again we are glad to welcome some few recruits to the Medical Profession as Freshmen within our Gates, but with the temporary lapse of the Students' Number we must ask them to forego the pleasure of reading the annual sermon which previous Editors have so ably delivered. At the time of the 1915 issue the position of the Medical Student was still largely a matter for speculation, but the uncertainty has passed with the advent of Conscription, or its equivalent, and we leave it to more competent advisers than ourselves to instruct and prophesy upon the future of the Profession. They will find that student life is much changed in these days, and there is but one ideal from the first, maximum effort in the work of the day. The Medical Profession is essential to the Army, Navy, and Country alike, and when the record of Medical Service during the War is written

they will have just cause for pride, provided they have done their duty by it.

The last twelve months has not passed by without leaving its mark indelibly impressed upon us. Many more Guy's men have died and suffered in their country's cause, and we in our hearts, while mourning for them, fear for what news the future may bring. Their honours bring us pride, but when, as often so cruelly happens, they have given the highest price how terribly do we feel their loss.

This war has fallen like an avalanche upon the nation; from the highest downwards no one was truly prepared and, justly or unjustly, one has heard from all sides and applied to all classes, implications of degeneracy and stagnation. It would appear that the nation as a whole was possessed of an all-obscuring self-satisfaction which was only slowly dispelled by the realization of the terror of war and the true intent of those who commenced it. Gradually the nation has so grasped the facts that to-day, the unity of our citizens, the fibre of our men, and the self-sacrificing co-operation of the vast majority of the masses, has brought about a change in our position rivalling the results of our enemies' carefully organised policy and preparation of a period of probably forty years. We appreciate the immensity of this national effort, and, referring to the Profession as a whole, we feel justified in a deep satisfaction in the manner and spirit in which the medical needs have been met, and in the unflinching devotion to duty of medical men, both old and young. Not for a moment do we claim any special praise for our own; still, the affection which common associations bring, leads us to dwell more upon their doings, their honours, and their sacrifice. We feel that Guy's men have "done their bit," and done it right well. However rusty we may have been, however unprepared for the rude awakening of field service, we feel proud that Guy's has made her effort.

On the one hand, many members of the Hospital and Teaching Staff are on active service or hold commissions in connection with the war. On the other hand, much valuable work has been carried out by which the labours of the diminished staff have been largely increased.

The following members of the Teaching Staff of the School have received leave of absence on account of the war: Sir Alfred Fripp, and Doctors French, Hurst, Hunt, Clark, and Johnson; Messrs. Turner, Davies-Colley, Eason, Layton, Mullally, Ozanne, Schlesinger, Heaton, McNair, Dowsett, Fry, Stranack, Price-Harris, and Pritchard. In every case before their departure satisfactory arrangements were made to carry on their duties. The School is indebted to Drs. Poulton, Pembrey, Laidlaw, Nicholson, and Ryffel, and Messrs. Bellingham Smith, Mollison, Trethowan, and Doubleday for voluntarily undertaking much additional teaching, while Messrs. F. D. Saner, Zamora, Tomes, Messenger, and Wright were appointed to act temporarily as teachers in the School. Mr. Symonds, formerly lecturer on surgery in the School, undertook at short notice to be responsible for a series of clinical lectures and demonstrations in the absence of Sir Alfred Fripp. Thus the work of the School has continued without the abandonment of a single course of lectures or demonstrations for undergraduates, although, almost without exception, the members of the clinical staff have undertaken service in the various hospitals for the wounded in and round London, and although most of the physicians and surgeons hold commissions in the Royal Army Medical Corps, T.F.

A special section of the hospital for the treatment of wounded officers was opened November 2nd, 1914, and has admitted 506 officers to date. They have come from many different theatres

of the war, British East Africa, South-West Africa, Singapore, Somaliland, Egypt, Gallipoli, and France, and there have been Canadians, Australians, and officers from the Indian Army, as well as from British regiments. Lieut. W. Kelsey, a Guy's man who obtained the Military Cross, was a patient in the officers' section.

About 100 wounded and sick soldiers from the Expeditionary Forces have been admitted to the ordinary wards, most of them requiring special treatment, as, for instance, fractured-jaw cases needing a combination of surgical and dental skill. In addition, over 1,000 recruits who required operative treatment to fit them for the Army have been admitted to Evelyn Ward, which has been specially set apart for this class of case since October, 1914. Nearly 3,000 recruits and men from the Home stations have been afforded relief in the Dental Out-patient, the Ophthalmic, and other Out-patient Departments.

It is pleasing to read in the daily press an appreciation of the British War Doctors, and although it comes from a formerly much criticised quarter, the ring is so true that we feel justified in our pleasure. Praise is deservedly given both to the R.A.M.C. and Staffs of the British Red Cross and Order of St. John.

Taken as a whole, the health of our armies has been admirable, and there could be no clearer proof of the efficiency and devotion of the medical organisations.

The lay appreciation of the individual deeds and sacrifices is more than welcome, and we thank the author for his graphic and splendid description of the war service of the Profession.

It has long been the experience in countries where Conscription is established, that a certain number of unusually reluctant recruits will go to the length of self-mutilation to produce unfitness for military service. In these days of war there is found an increase of these cases, and inconceivable though the state of mind may be, there are those who, for profit, will aid or abet the malingerer. It is only recently that definite regulations have been issued under the Defence of the Realm Act for dealing with these cases. As they stand the Regulations would seem adequate enough and required only to be put into force, rigorously and without favour. It is equally an offence to assist an intending malingerer by producing mutilation or by supplying him with drugs wherewith to "dope" himself, and so on.

Such decisions are definite enough, but there is at present no statement that the signing of any certificate of medical unfitness to enable a recruit in an attempted imposition on a Medical Board or Tribunal is a punishable offence. Undoubtedly there have been such cases, although not always has the error been wilfully committed. A definite regulation would at least ensure more care being taken over the distribution of certificates, and undoubtedly much outcry would be spared against the occasional vagaries of Medical Boards and Tribunals, directly originating from careless or erroneous certificates.

We publish later a letter from Mr. Thomas Morley, formerly Janitor to the Medical School. We are glad to say that the subscriptions towards the Testimonial presented reached quite an excellent figure, and we thank all who assisted us on Mr. Morley's behalf.

Our War Savings Association has only been in existence since August 1st, 1916, but can already boast of 221 members. These, drawn from every department of the Hospital, have already subscribed over £100. A mass meeting to explain the purposes of the Association was held as a preliminary, and collectors for every department were appointed

by the Committee, notices to that effect being posted everywhere so that all might know where to find their collector. Two hundred and three subscriptions were taken the first week (6d. being the unit), and in the fifth the number of new ones had risen to 931, while eighty-three certificates have already been alloted. The certificates with the earliest dates are given to those who first complete their payments; if several finish on the same day preference is given to those who began first, while if several began and ended on the same day the certificates are given in alphabetical order,

We had grown used to Zeppelins and used to disappointments as we watched them rise and disappear with a lightened load of bombs into the sheltering cloud banks, but miraculous though it may seem we now hasten to our "posts" undismayed by the concussions of bomb and gun with but one thought. Shall we be able to see that terrible increasing glow in the heavens as the apparently inevitable toll of the raiders is taken? We feel that the public press has not exaggerated the wonder of these recent spectacles.

Overheard at a bookstall less than a mile from Guy's:

"What Nursing Papers have you, please?"

"Afraid we're sold out, Miss."

"Oh! well, give me the *London Mail*, will you?"

And her uniform was blue, too!

Undoubtedly the state of knee-jerk can provide most useful clinical information, and the importance of its absence cannot be exaggerated. We hear that, to determine this latter condition, the hand should first be tried, then the bed letter followed by the temperature chart. If all these fail, the wool scissors smartly applied to the centre of the patella will decide the point once and for all.

The Living Wage.

A Reply.

"A sufficient income is necessary for the practice of virtue."—G.B.S.

The letter from Quondam Editor in the last issue of the Gazette, though short, raised a number of interesting points. Perhaps its brevity was the reason why he begged the real point at issue in so remarkable a way. Contesting my statement that financial reasons were the only ones strong enough to drive a girl upon the streets whether—as I was careful to point out—the direct stimulus of hunger, or what is infinitely more common—the perfectly normal desire for freedom and self-adornment felt by every young animal, he says that "personal observation, enquiry, and the experience of married men and women" (though the opinions of members of the "greatest trades-union" hardly strike one as being unbiassed) would convince me that a glib seducer, aided by alcohol and whatnot "is the initial step in countless cases. The servant class illegitimacies arise from sheer ignorance, feeblemindedness, inability to refuse a lover, &c., *but never from poverty, and never from choice.*" Frankly such reasoning makes me gasp. Whether a girl has been "ruined" or not is really no business of anyones, in spite of the efforts of rescue societies to make us believe the contrary. No one outside the columns of a newspaper *feuilleton* has ever heard of a duchess being ruined, nor founds guilds to redeem the fallen daughters of millionaires. They know quite well that for persons economically independent the market value of chastity is nil. In every class of society in Germany, Japan, and the Scandinavian countries; in the peasant and artisan classes throughout the world (with the exception of Catholic Ireland), *i.e.*, in those countries where the possession of a *dot* is an

essential marriage condition, or where the woman by her manual skill makes her share of the partnership a profitable one, the greatest pre-marital license is tolerated. The freedom said to prevail in our own "Smart Set," that which undoubtedly exists in industrial England is, viewed in this light, perfectly understandable. The chastity of the middle classes, where the girls' only career is marriage, is the modern survival of the ethics of the slave market, the difference between new and damaged goods. A woman either by her patrimony or her labour financially independent of marriage cannot be ruined in the technical sense. She is free to indulge herself when and where she pleases. The case, then, of our servant girl is perfectly plain. In allowing herself the experience of motherhood without ensuring the assistance of the father she has incurred an expense which she cannot afford.

Without means, it is difficult to see how prostitution can be avoided. That, indeed, is the whole tragedy of her situation. No crime, in England, at all events (perhaps because this is a "free" country), is so severely punished as unmarried motherhood. That is, of course, when the mother cannot afford to pay cash down for the luxury. If she can afford it, it is only necessary to assume the courtesy title of Mrs., and wear a wedding ring, and she will have local society ready to receive her with open arms. The servant girl's only crime, as is natural in a land where cash payment is valued above healthy citizens (that is, payment in kind), is that of insolvency. The wages of domestic servants do not, as a rule, allow for keeping a family, and she has therefore to choose between abandoning her offspring, and the only alternative, prostitution. For it is a curious and somewhat ironic fact that the only employments open to women at the present time which offer them reasonable prospects of a competency are the two which mostly rely on the exhibition of sexual attractiveness—the stage and the streets (excluding the highly trained professions, medicine and the like, which are beyond the reach of 99 per cent). Assuming, then, our servant to be without the necessary attributes for a success on the boards—as we have every right to do—there is no alternative to prostitution. But, be it clearly understood, the reason is purely one of underpayment. Pay your domestic a reasonable living wage, recognize her right to motherhood, and you have one street walker the less. The question of the payment, or rather underpayment, of women is one in which I cannot enter here. I have already dealt with it in a series of articles in the Gazette entitled the "Position of Women" early this year. But that women are driven into prostitution by insufficient wages, nay, that money so earned is deliberately allowed for by many employers in calculating their scale of payment is proved beyond all cavil.

Nevertheless, the fact remains that Q.E. offers no explanation save the economic one for the phenomenon of prostitution. He has, I am glad to say, done me the justice of calling my picture of "naturally virtuous women driven to vice by economic necessity" an unwitting one. Though they be corrupt as Catherine de Medicis or sensual as Mademoiselle de Maupin, their vice or virtue has no relation to the point at issue, which is simply that in search of their daily bread they should choose to offer their bodies to the highest bidder. Does my correspondent imagine that they take up the life as a hobby? Does the existence of the average harlot impress him as being one of ease and security? Do those with whom he has conversed seem enchanted by its romantic glamour? He must be a very superficial observer indeed if it has. The truth is that the life, whatever its outward attractions may be, is one requiring an iron physique and a keen business instinct. It offers, it is true, a relatively high rate of payment, but the risks are many and the productive period short. It

is one of the dangerous trades. What, then, are the predisposing factors which induce a woman to take it up? First, let us put aside sexual emotion. An illegitimate child is certainly a very frequent cause, disgust with the humdrum routine of service or the factory another. A desire for beauty, reasonable time for recreation, love of music, brightness, joy—all that the life of the working girl could, but does not hold, these are the baits offered to recruits for the oldest of the world's professions. A keen religious sense may deter some, the hope of marriage others, real knowledge a few, the rest hold back from fear of public censure—in a more favoured walk of life we should say they lacked "spirit." But all this is beside the real point at issue. Make woman economically free, emancipate her from the claims of man upon her sexuality, guarantee to every woman who cares to work a decent livelihood in hygienic surroundings, where she can, if she will, bear and rear her own children, and the traffic of the streets will cease, as it has already ceased in Australia, South Africa, and New Zealand.

One word as to the attitude of society in England towards the "fallen." My correspondent says, quite justly, that the majority would not and will not give up the life. Has he ever considered the appalling difficulties presented by any such attempted regeneration? In many countries prostitution is a seasonal occupation. In Paris the *trottin* takes to the streets only when the millinery workrooms offer her no employment; in Vienna periods of agricultural activity coincide with a marked decrease in the number of prostitutes.

In ancient Greece the lady of easy morals was the honoured consort of emperors and princes. But in twentieth century Britain she is a social outcast. Represented on the stage with the accompaniment of wine, laughter, and song, idealized in romantic fiction, theorized over, sentimentalized over, she is, in actual fact, a pariah, the enemy of society—and she knows it. What wonder if these unfortunates refuse to caress the hand that has struck them, or that their pride revolts against the acid ministrations of the rescue worker. Respectability has degraded and abased them, they will at least go to their doom with a smile on the lips, and hatred in their hearts. Their fate will have none of the isolation of great tragedy. Not the plains of New Orleans but a frowsy tenement off the Brixton Road will see the last hours of these modern sisters of Manon Lescaut. And shareholders will smile as they draw their ten per cent. from shoddy clothing factories and chorus girls remain virtuous and walk home with empty stomachs. And idle spinsters will continue to propound idle theories to account for the whole extraordinary business.

But we, Mr. Quondam Editor, with our trained and observant minds, let us, in the name of our national honour, bear in mind the hideous fact that in 1914 the average weekly wage of five million women workers was under thirteen shillings a week. For it is only by doing so, that we shall in the days to come be spared the supreme spectacle of motherhood rearing her offspring by the barter of her own soul.

G. H. F. G.

Correspondence.

To the Editor of Guy's Hospital Gazette.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

Dear Sir,—May I be kindly allowed a small space in the columns of the Gazette to express my sincere thanks to the Staff and Past and Present Students who have so kindly contributed to the Testimonial presented to me on my retirement from Guy's, also for the many kind wishes received, which I much appreciate.—Believe me, sincerely yours,

43, Stockfield Road, Streatham, S.W. THOMAS MORLEY.

Letters from Old Guy's Men on Active Service.

I've been meaning to drop you a chit for some time, but have not been in the mood to really sit down and talk to you properly. Anyhow, I will try now and give you a few details of my month of travel. I left England, as you remember, exactly a month ago yesterday, on H.M.H.S. Valdivier, and arrived at Malta in exactly the week. Experiences on the voyage were many and varied. At tea in Southampton I met four lady doctors, and, of course, the one question was, Where are you going? In the end this was put to me, and my reply was Bombay, followed by, Oh, where is that? This, of course, settled what we eventually nicknamed the Scientists in my mind.

Well, the first forty-eight hours went by with one or two exciting incidents which the Censor would forbid my mentioning here, but the Scientists and four or five Sisters and two of the M.O.'s fell sick of mal-de-mer, and I, feeling just on the top of my form, thought, well, 1 c.c. of T.A.B. would do me no harm. So down I went and had it just in the pectoral region. I had instructions from my C.O. that I was to be T.T. for forty-eight hours (by-the-way, he was just a topping fellow, came from Derby, knew Barber and Tommy Hicks jolly well). After dinner I was challenged by him to a game of chess, and we combated to such an extent that he was forced to have a W. and S. before he took a certain move, and, like the devil he tempted me, and I fell to a similar drink much to his amusement, and really, I swear it can't have reached the cardiac end of my stomach before it had well settled in the inoculation area, just giving me fits. Still, this lasted barely fifteen minutes and I was normal again (interesting experience from a professional point of view), and managed to win my game.

Sunday came and we passed Gib. in a thick fog. but not thick enough to prevent Church Service on the lower deck. This was very impressive, indeed, and the crew and Tommies (R.A.M.C. orderlies) sang "For those in peril on the sea" right royally. In the afternoon the C.O. asked me to give him a private instruction in the working of the X-ray apparatus on board, as neither he nor any of his M.O.'s knew anything about it at all. This we did in some style, it being a 12in. coil one, and after tea we had an inspection and lecture on it with the whole of the hospital staff (this, of course, was rather heavy, I might tell you). The night before we arrived at Malta we had a concert for the men, and I was called upon for a song. We sang some of the old Nigger stuff, but the song that went down was "Pack up your troubles in the old kit bag," and I believe up to to-day it is the song of the ship.

Well, at Malta I was disembarked and told I should have to wait for forty-eight hours, but eventually it was twelve days. I stayed at the Osborne Hotel, the best in the place, but they have a composite fee fixed of 10s. a day including everything. Of course, I took full advantage of the visit and saw most things. Malta is quite a nice place and very reasonable in prices, but I expect by now you've seen Harky, and he has told you the news. If you see him, quietly go up to him and ask him where he left his "false teeth"? Now, I was awfully bucked there, as I met a friend who told me Harky was the most popular surgeon in the Mediterranean. "Good old Guy's!" Others I met were Constant (X-ray specialist to the island; ten minutes' work a day, according to himself); D. A. Mitchell, at the Naval Hospital, who was jolly good to me, and asked me to several bathing picnics—the thing at Malta; Jack Elliott, A. M. Henry, and the elder Willan on H.M.H.S. Karapara; the latter was really my home—they were absolute sports to me and I had many a meal on board with them. We were hon. members of the Union Club for one week, and, of course, I met many naval pals of mine and learnt some gag!!!

Well, eventually I had orders to proceed by H.M.H.S. Herefordshire, and then to my huge delight I ran into old Dan Druitt. He, of course, took me in hand, and showed me the run of the ship, and I found amongst the passengers Vance, Portway, Campbell, and one other whom I forget, and an old Guy's man, by name Lewin, and so we were well represented. On the Saturday and Sunday we had sports, and I entered for everything possible and got into three finals and one semi-final, but I skippered the Passengers' Tug-of-war team v. the Orderlies, etc., and we won in Pukka style by two straight pulls, pulling the old Guy's fashion, you know, à la draw.

Well, we arrived here and were sent to a Rest Camp, and the first man I saw was my old H.-S., T. F. Brown; so again I was lucky. He was jolly good to me, and showed me around, etc. Now, of course, this is a beautiful place in many ways, most interesting and very cosmopolitan. The Guy's men I've met here are Graham, Doll, Sandison, McDermott, Foster-Smith, and Col. Eason. To-day I've seen Col. Eason and T. F. Brown off back home, the former was in splendid form and was awfully decent to me. You will be seeing these two very shortly and they will, no doubt, tell you they met old H.N. Now, of course, my one worry is the fearful slack life, absolutely just nothing to do except censor letters for the Adjutant every morning at dawn. We arise at about 5.30 a.m., but this is nothing, as you sleep in a tent and the air, of course, is topping, and another factor is that I'm practically T.T. since I left home, occasionally have a w. and s. after sundown. But I've been orderly officer once; duties many and varied, mostly inspection of food and meals, but I

was detailed to inoculate 150 men (recruits from England) with cholera. But one good gag was the saving by Schafer and other methods of the apparently drowned after 35 minutes of hard work in a broiling sun. I got complimented by my C.O. for this, and the man is alive to-day with no further developments such as pneumonia.

Two days ago at Biekka who should stroll in but Jimmy Jarvie and Geo. Kidman and young Pryn, and they are still with us. I expect to move on at any moment, and, please God, I shall, as I'm sick to death of idling away my time. This is not swank, but really you know I like working if it has nothing to do with *books*. Oh, I forgot I met Brian Metcalf also in the street. He is in a H.S. as a surgeon, and, oddly enough, had had my younger brother under his care.

Well, old man, this is more or less of a diary of my doings up to date, and you can show it to whom you please, but I fear it is not good enough or interesting enough for old Knott's publication. Still, I promised I would let you know how I fared. Of course, if only I could get some work I should be quite happy as I love the life in camp, and shaving in cold water and sleeping in a flea bag, it is grand sport; I would just love to see old Reggie and Sam doing it, especialy old Sambo; think of shaving in a sandstorm, no London Bridge Approach to go to and buy a shave!!

How are you, old man? and how are the many old Departments? I hope you are well settled in by now and the work is done. I felt rather rotten going as I did, but I fear it was a necessity as far as I was concerned. Do write and tell me all the news and gag. I wish you, old sportsman, the very best of luck, and the same, if you don't mind conveying it, to all at Guy's. H. N. E.

P.S.—I am as brown as a negro.

After a delightful voyage out here and a short stay of about a week in Alexandria, Jarvie and I have been sent to this unit. We are in the Wilderness, but on the outskirts of it, and we get plenty of bathing and see some shipping. This is a very romantic country with its historical associations, but I don't know how the Israelites stuck 40 years of it.

The work here is very little, and probably we two will be separated, but not far I hope. There are the usual camp duties every day, which are relieved by the presence of a small hospital of 50 beds or so into which we receive the sick of the neighbouring regiments. There is very little sickness and no wounded, although there may be some scrapping when the winter comes.

The ambulance has been short of officers for some time, and several regiments are without M.O.'s, but as there was little work it did not matter. However, these units have to be up to strength, I suppose, in case something happens. The heat is more bearable down here than in Alexandria; according to the papers we struck a heat wave there. We saw H. N. waiting for a ship, and I think he left the camp the same day as we did; he had been there a fortnight and was getting very fed up. We also met Sandison and Doll, whom Jarvie knew, and went to a music hall one night.

Jarvie and I are the only ones into mess to-night, The other fellow and the Colonel are dining out. Th Colonel is one of these martyrs of the Empire who have spent their lives stationed in various possessions.

Things seem to be going well in France, but the end, no doubt, seems far off. I should like to see things settled before next June, or I shall be a grease spot if I am out here. The weather is getting nicer everyday now. You must see that I am at a loss for more to say. I hope you are keeping in very good condition in spite of your arduous job.—Yours very sincerely, GEORGE KIDMAN.

Change of Address.

Temporary Lieut. R. L. Portway, R.A.M.C., Mesopotamia Expeditionary Force, c/o India Office, Whitehall, S.W.

Capt. L. Horsley, R.A.M.C., from 1, Poplar Walk Croydon, to 13th General Hospital, Boulogne.

A. S. Erulcar, M.D., B.S. Lond., Cook's Buildings, Hornby Road, Fort Bombay, India.

Capt. W. S. Richardson, R.A.M.C., 46th (1/1 Wessex) Casualty Clearing Station, B.E.F.

Edgar B. Williams, from 14, Princess Square, to 2, Mansion Villas, Tavistock Road, Plymouth.

C. Jephcott, Abbot's Rock, Chester.

Temporary Surgeon E. G. Schlesinger, F.R.C.S., 63rd (R.N.) Division, to 18th Casualty Clearing Station, B.E.F.

Temporary Surgeon B. Burnside, from R.N. Hospital, Haslar, to H.M.S. *Vindictive*, c/o G.P.O.

Pte, A. Weinberg, A.M.C., South African Military Camp, Richmond, Surrey.

Capt. V. F. Soothill, R.A.M.C., from 9th Field Co., to 32nd Stationary Hospital, B.E.F.

Lieut. A. Traill, Officers' Mess, No. 5 Camp, Codford, Wilts.

Surg. Prob. P. W. Cutts, R.N.V.R., from H.M.S. *Narwhal* to H.M.S. *Laertes*.

L. S. Pilbeam, Room 12, B. Reserve Brigade, Royal Horse Artillery, St. John's Wood, N.W.

H. W. Eddison, late H.M.S. *Ithuriel*, c/o Admiralty, Whitehall, S.W.

Capt. H. G. Dresing, R.A.M.C., from 3rd Pontoon Park, R.E., B.E.F., to 1st Queen's Royal West Surrey Regiment, B.E.F.

Trench Fevers.

CLINICAL LECTURE BY DR. HURST.

In the early summer of 1915 Major J. H. P. Graham drew attention to a type of fever occurring in the British Army in France, in which two periods of pyrexia were separated by a normal interval. Similar cases were recognised with increasing frequency, and the disease soon became widely known as "trench fever." In November, 1915, Captain G. H. Hunt and Major A. C. Rankin described thirty cases of the same type of trench fever, and a still fuller account was published in February, 1916, by Captain J. W. McNee, Lieutenant A. Renshaw and Captain E. H. Brunt, in which for the first time two distinct clinical types were distinguished.

The disease was only observed among officers and men living near the trenches, and in the personnel of hospitals, especially among orderlies of wards in which there were patients suffering from the disease. No cases occurred among ammunition columns, ordnance, and headquarters troops. It was for this reason that the name "trench fever" was adopted, though actual residence in the trenches themselves was certainly not an essential factor, and Hunt and McNee, in their most recent communication, state that cases have lately been met with further from the front.

Literally thousands of cases of the first type occurred among the troops in France and Flanders between the end of April and October, 1915; it was comparatively rare in the following winter, but increased again in the spring of 1916. It did not occur in Gallipoli and was not definitely recognised in Salonica until April, 1916. The second type, which was rare in France and Flanders until November, 1915, when it became more common than the first, has been very prevalent in Salonica since December, 1915. At first cases had to be recorded as "P.U.O." (pyrexia of unknown origin), or under the head of influenza or some other equally incorrect name, even when their nature had been recognised. For this reason it became customary to call the disease "pyrexia of unknown origin (A)," or shortly, P.U.O. (A), as this designation did not introduce into the official records an unauthorised name, such as "periodic one day fever" or "Salonica fever," which had been used by some medical officers. The term trench fever was not used, as besides being an unauthorised name, the disease was common in Salonica at a time when no men were living in the trenches, and cases occurred in ammunition columns several miles from the trenches as well as in front line troops and in hospital orderlies. When, however, in March, 1916, we recognised that the disease was identical with the long form of trench fever described by McNee, Renshaw and Brunt, and when a month later the common short form of trench fever seen in France and Flanders became prevalent in Salonica, it seemed wise to adopt this name.

A few cases with symptoms intermediate between the two types of trench fever have been observed in France and in Salonica, and the initial symptoms are very similar, but the temperature chart is so different in typical cases, and the second class occurred in such large numbers without the first in the winter months, although it was very rare in comparison with the first during the summer of 1915 in France, that it cannot yet be regarded as finally proved that the two diseases are really due to the same infection, as is generally believed by British observers in France.

With the exception of one man, who contracted the disease whilst in hospital from another cause, all of the cases observed in Salonica up to March, 1916, belonged to two divisions which had been several months in

France. None had been in Gallipoli or Serbia. The short form of trench fever had occurred in several of the affected units whilst they were in France. It is highly probable that these divisions brought the infection with them. In March, 1916, the periodic form of trench fever began to occur in a division which had been in Serbia, but not in France; some of the men had been in Gallipoli, but most had come straight to Salonica from England. In April groups of cases of both forms of trench fever appeared in units belonging to other divisions, which had been free from the disease since their arrival at the end of 1915. The infection in the later cases was probably conveyed by men coming in drafts from France. The disease also developed among the personnel of some of the hospitals, to which the patients were sent.

Trench fever has not been observed among the French troops in Salonica, and it does not appear to have been prevalent among them in France. It has occurred among Austrian troops in the Tyrol and among Germans on the eastern front.

Pathology.—Before trench fever could be accepted as a clinical entity it was necessary to prove that it was not an aberrent form of some other condition, such as paratyphoid fever, which it may closely simulate during the first pyrexial period, true relapsing fever, which it resembles in so far as the fever is of a characteristic relapsing type, and malaria, which is sometimes simulated by the shorter and sharper pyrexial attacks. But the blood taken at the height of both the initial and the later febrile periods has always been sterile on cultivation, the Widal reaction has been consistently negative at every stage of the illness, and no spirochæte nor malarial plasmodium has been found in spite of repeated examinations of blood films taken during both febrile and afebrile periods.

McNee and Renshaw found that trench fever could be transmitted to healthy soldiers by the intramuscular or intravenous injection of the blood of men suffering from the disease. Injection of the washed red corpuscles had the same effect, but the plasma and serum were not infective.

One attack does not seem to protect against re-infection. I saw a man with the long type of trench fever in April, 1916, in Salonica; he had been seen by Captain McNee in a typical attack in September, 1915, while in France, and had been quite well in the interval. It is possible, however, that there was no re-infection, the original infection having remained latent between the two attacks.

As all attempts to discover the infective organisms have failed and as no fatal case has occurred, the nature of the disease remains unknown. The striking periodic character of the fever in the long type of case, the considerable increase in the proportion of large mononuclear leucocytes, which has been found on several occasions, and the evidence pointing to an intracorpuscular infection suggest a protozoal rather than a bacterial origin.

Method of propagation.—There is no nasal, pharyngeal or bronchial catarrh, and, except for constipation, gastro-intestinal symptoms, though occasionally well marked, are generally completely absent. It is probable, therefore, that the disease is not conveyed by the respiratory secreta or by the fæces, but through the intermediation of some insect. The occurrence of the long form of the disease during the winter months shows that the infection can be conveyed in the absence of mosquitoes and other flying insects; though Herringham found mosquitoes in France throughout the winter, there were certainly none in Salonica. Fleas have been scarce in both countries, and the men themselves rarely complain of them. Almost all patients admitted that they were lice in-

fested up to the time of their entry into hospital, so that it is quite possible that the disease is conveyed by lice. A hospital orderly, who had been free from lice since his arrival in Salonica, had to carry the kit of a number of new patients suffering from trench fever on May 2nd, 1916. The clothes were swarming with lice, and the same evening he found some in his own clothes. He got rid of them in the course of a few days, and on May 20th an attack of trench fever began. He was not employed in the wards, he never came in contact with any patients suffering from the disease, and he was the first case of trench fever in the personnel of the hospital to which he was attached.

The incidence of trench fever is least in the cleanest battalions and in the divisions which have the best facilities for bathing. In some units a successful campaign against lice has been immediately followed by a great diminution in the incidence of trench fever, and the campaign against lice in the whole Salonica Army in the spring and early summer of 1916 was followed by the almost complete disappearance of the disease. Captain A. L. Urquhart developed the short form of trench fever after allowing the lice from a patient with this form of the disease to bite him, and Captain McNee tells me that his observations in France have led him to agree with the conclusion I came to in Salonica—that the disease is spread by lice.

Cold, wet, and fatigue appear to be exciting causes in a man who has become infected, but has so far had no symptoms; thus Captain Hay noticed that almost all cases in his regiment in Salonica began two or three days after they had been wet through. In several instances a group of men sleeping in the same tent have been affected.

Some patients appear to be carriers, who do not lose the infection completely for several months, but have recurrences from time to time, during each of which they may infect an additional number of men. A sergeant, who had been in good health whilst in France between December, 1914, and November, 1915, developed the periodic form of trench fever early in December, 1915, directly after he left France for Salonica; in the following four months he was in hospital five times for a week or more, though he was perfectly well in the intervals. Every time he returned to his unit he became lice infested again and appeared to infect most of the men with whom he came in contact, about forty men of his company, including six sergeants, having been taken ill with trench fever between January and March; one of the sergeants had wrestled with him, another had danced with him, a corporal slept next to him, and a private sat next to him for some lectures.

Incubation Period.—As a result of observations in Salonica on cases arising in hospital, when a patient had been admitted for some other condition, I came to the conclusion that the incubation period is between 15 and 25 days; in the case of the hospital orderly already described it was probably 18 days. Quite independently Hunt and McNee in France concluded that it was between 14 and 24 days. The following cases are typical of those which led to my estimate of the incubation period:—

(1) Sergeant B., R.E., was admitted for rhinitis on December 27th, 1915, into a ward in which there were at the time two patients suffering from the periodic form of trench fever, no other cases of which had been observed in his unit. On January 1st, 1916, he was moved into another ward in which there were and have since been no such cases. When convalescent from the rhinitis, which had been accompanied by no pyrexia or pains in the head, back or legs, he suddenly became ill on the evening of January 24th; his temperature in the morning was normal, but at 6 p.m. it was 104°. This proved to be the first pyrexial period of a typical attack of the periodic form of trench

fever. It is probable that the infection was contracted from the other cases in the ward between December 27th and January 1st., between 23 and 27 days before the onset of symptoms.

(2) Private W. went to France at the beginning of the war with the 1st —— Regiment. He was wounded in January, 1915, and was in England until the end of 1915, when he came to Salonica, joining the 2nd —— Regiment, which had come there from France in November, on January 13th, 1916. A few days after he arrived he became lice infested. On January 21st he went to a field ambulance and then to a casualty clearing station with a hydrocele; he was transferred to a stationary hospital on February 6th. On February 12th his temperature rose and a typical attack of the periodic form of trench fever began. His clothes were disinfected when he entered the casualty clearing station, and he had no more trouble with lice after his admission there. It is probable that he contracted the disease whilst with his regiment, *i.e.* between 24 and 16 days before the onset; as he was not lice infested until he had been with his regiment some days, the period was probably about three weeks.

Symptoms.—The disease generally begins suddenly without any premonitory symptoms, but a feeling of malaise occasionally precedes the attack for a day or two. The patient complains of severe headache, especially frontal and behind the eyes, and this is rapidly followed by pain in the lower part of the back and on the second or third day in the legs. Pain in the neck is occasionally observed; in two cases mentioned by Hunt and McNee pain and stiffness in this region were so severe that a lumbar puncture was performed in order to exclude meningitis, and I also saw two cases in Salonica in which this was done. The patient generally shivers, but there is never a definite rigor; he is occasionally flushed and often sweats profusely. The bowels are regular or constipated and there is no nasal or bronchial catarrh; the appetite is lost, the tongue is moist and often slightly furred, and occasionally mild pharyngitis is present. Herpes labialis has occurred in a few cases, but less frequently in the long than in the short form of the disease. There is no rash.

The onset is sometimes extremely abrupt; the patient suddenly feels giddy, his legs give way under him, and he shivers; he may be very short of breath and complain of a pain in his left side. He has to fall out if on parade or marching, and has often great difficulty in returning to camp without assistance.

In a few cases, in which constipation is generally present, there is some abdominal pain with slight distension and tenderness, and there may be nausea and vomiting at the onset. Four out of my first fifty cases of the periodic type were sent to hospital diagnosed as appendicitis; in one a normal appendix was removed, and a second would have been operated upon had he not refused. The abdominal symptoms rapidly disappeared, and in the relapses they were less prominent than the other symptoms.

When the pain in the legs is severe, there may be some cutaneous hyperæsthesia over the shins. The shins are always tender, even if the patient complains of no pain in the legs, but tenderness appears to be most marked in groups of cases and at certain times. Graham did not mention it, and it was not observed in the earliest cases in Salonica. In several cases the periosteum of the tibia has seemed to me to be rough and thickened, as it pits slightly on pressure, although no pitting of the subcutaneous tissue was present. The tenderness is most marked over the lower half of the shins and may be very severe, a comparatively slight pressure causing the patient to cry out, and the pain produced may last for hours. A less degree of tenderness is often present in the

tendons behind the knee, and occasionally in the ligamentum patellæ and along the course of the femur. There is little or no tenderness of the calves or other muscles. The knee and ankle jerks are normal, and there is no evidence of neuritis, though a considerable degree of muscular atrophy may occur.

In the first attack the spleen is sometimes palpable or is found to be enlarged on percussion, and there may be some tenderness in the left hypochondrium. Although this was certainly the case in Salonica, Herringham, Hunt and McNee never found any splenic enlargement in the cases they observed in France.

Leucocytosis is often, but not always present during the pyrexial attacks; the count varied between 4,700 and 22,000 per c.mm. in 35 cases, mostly of the short type, examined in France; in many of the cases examined both in France and in Salonica there was a relative increase in the large mononuclear cells. Polychromatophil cells above the normal size with well-marked punctate basophilia were observed by McNee, Renshaw and Brunt in France, but Elworthy, working in Salonica, came to the conclusion that they only occurred in the later stages of the more severe cases. The percentage of hæmoglobin is generally about 80, though the number of red corpuscles is undiminished.

In the *short form of trench fever* the temperature rises rapidly to between 102° and 104°, but the pulse rate is only slightly increased. On the third or fourth day the temperature suddenly falls—generally to normal or subnormal, but there is no corresponding improvement in the symptoms. After an interval of a few hours it rises again, and then after another two to five days it falls to normal; on this occasion there is immediate relief to all of the symptoms (Chart I.). In some cases the remission on the third or fourth day does not occur, the temperature remaining raised for about a week. There is often a single relapse after an interval varying from a few hours to ten days, but generally less than four days; the temperature rises to 100° or 101° for 24 or 48 hours, during which the symptoms return with diminished

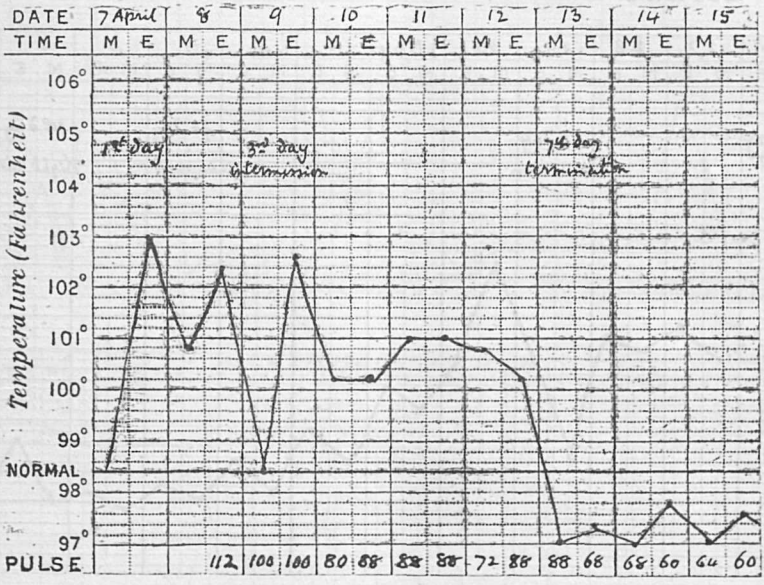


Chart I.—Short form of Trench Fever.

severity (Chart II.). The patient is generally fit for duty almost immediately after the temperature falls again. Many cases have been kept under observation by Hunt and McNee for weeks or months after the fall of temperature without any return of fever or other symptoms, so that there could be no question of additional relapses occurring after the patient had been discharged from hospital.

In the *long* or *periodic type of trench fever* the temperature rises to between 101° and 104° on the first evening. The initial attack is variable in duration; the temperature may be normal the first morning, high in the evening, normal the second morning, and rather less high the second evening than the first, after which it remains down. In other cases the first attack may last as long as four or five days, the temperature being always lower in the morning than the preceding and following evening, the highest temperature being reached on the second or third day; in one case it reached 105·8° on the third evening, though it was normal the previous and following mornings. The pulse is generally accelerated in proportion with the temperature, but at first it may be considerably faster. With the fall of temperature at the end of the initial attack all the symptoms disappear and the patient is often sent back to duty.

After being well for two to ten days he complains of a return of headache and pain in the legs, which culminate at night; the temperature rises in the evening to a point which is generally a little lower than the highest temperature in the first attack. The temperature falls to normal or nearly normal the next morning, and either remains down or rises to a less extent the second evening, thereafter to remain normal. The general symptoms are much less severe than in the first attack, and the acceleration of the pulse is less marked, but the pain in the legs and tenderness of the shins are generally greater, and they may not disappear completely in the interval between the second and third attacks, though the headache, which generally remains the most prominent symptom during the attack, is never present in the apyrexial periods. The pain in the legs is sometimes extreme and may prevent sleep: in other cases it is comparatively slight and the patient looks

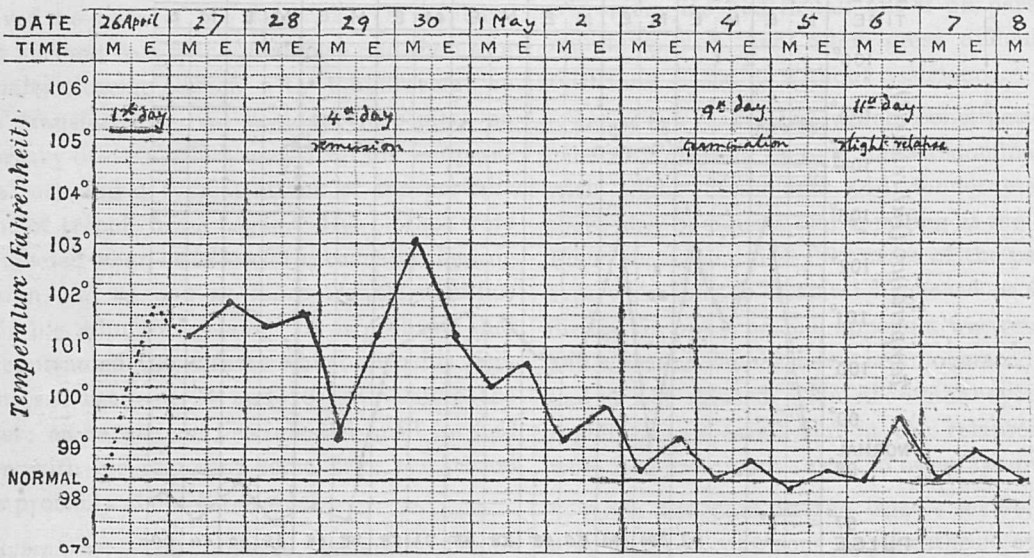


Chart II.—Short form of Trench Fever.

and feels remarkably well, considering that he has a temperature of 101° or more.

Recurrences follow periodically, the maximum temperature being always reached in the evening (Chart III). The intervals between the height of the attacks is fairly constant in each case, but it varies in different cases between four and eight days, five being the most common interval. Each succeeding attack is generally milder than its predecessor and the temperature

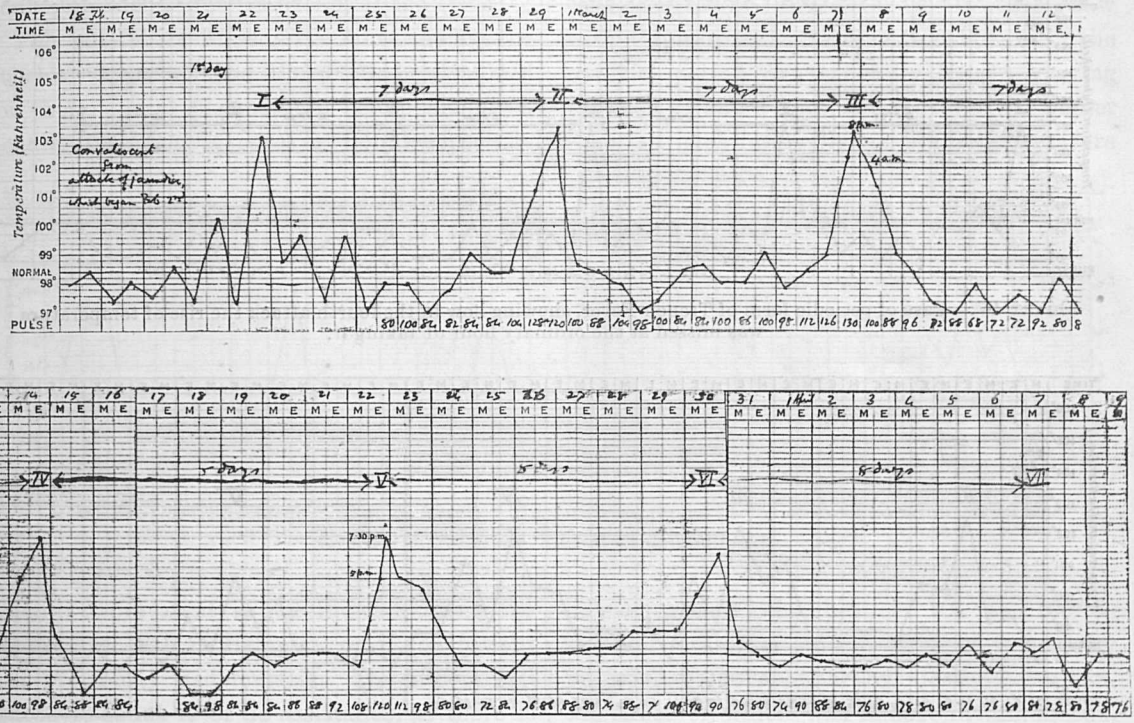


Chart III.—Periodic form of Trench Fever.

is rather lower, but in severe cases the patient feels weaker in the later intervals, and the pain and tenderness of the legs are more persistent. The later attacks may be of such short duration that the rise in temperature is not recorded at all if it is only taken twice a day (Chart IV). On the afternoon and the evening of the day on which the attack is expected the temperature should therefore be taken every two hours, especially if there is any pain in the head or legs, as in most cases the patient knows from his sensations that there is going to be a relapse, even before the temperature rises. The temperature is sometimes only raised for three or four hours: in one case, for example, the morning temperature was 98°; at 5.30 p.m. it was 99°, at 6.30 p.m. 100° and at 8 p.m. 101°; at 9 and 10 p.m. and at 8 a.m. the following morning it was 98·4°. In another case it was 97·6° at 5 p.m., though the patient had had a headache since the morning, but 101·2° at 8 p.m., 102·4° at 10 p.m., 101·4° at 2 a.m., 100·2° at 6 a.m., and 98° at 8 a.m., so the morning and evening chart showed no rise, as the temperature in the ward was taken at 8 a.m. and 5 p.m. This liability for the rise in temperature to escape recognition accounts for the fact that it may appear from the chart that an attack has been missed, the interval between two of the later attacks being double that between the earlier

ones : a headache may have been felt and a rise in the pulse rate recorded halfway between the (Chart V.)

In a few cases the temperature remains raised for three or even four days in each attack, the evening temperature being always higher than the morning temperature, which may be normal on the first and last days ; the highest point is generally reached the second evening (Chart VI.)

pyrexia whilst the patient is still at duty escaped notice. Some of the cases regarded as examples of the short form of trench fever are probably really periodic cases, as there is no doubt that the later bouts of pyrexia are often entirely missed owing to the short time they last, the patient having meanwhile gone back to duty, or if in hospital the evening temperature may have been taken at 5 p.m., although the rise

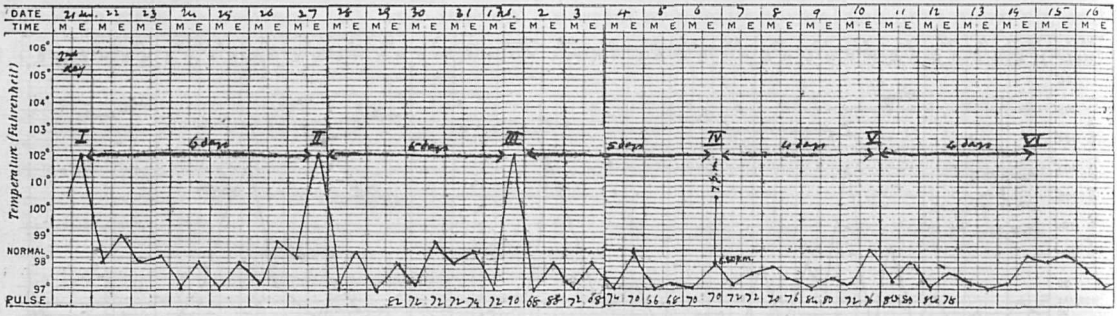


Chart IV.—Case of periodic form of Trench Fever, showing how in the fourth attack the rise of temperature was missed at the ordinary hour of taking it.

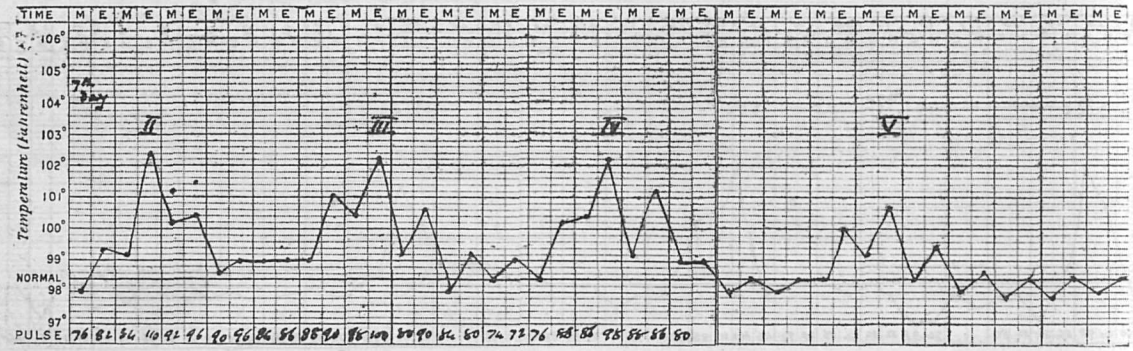


Chart V.—Periodic type of Trench Fever with each attack lasting three days.

Diagnosis.—The diagnosis can only be made with certainty from a study of the temperature chart, but the association of pyrexia with tender shins is very suggestive of trench fever already in the first attack. Painful and tender shins have, however, sometimes been observed in the Salonica Army in the apparent absence of fever, and the unsatisfactory name of "trench shin" has sometimes been used to describe such cases. It is, however, probable that slight initial

only began at 7 p.m. or later. Several medical officers, who were very familiar with the early stages of the disease, only recognised the periodic rise of temperature after their attention had been specially drawn to its occurrence, as their patients had returned to duty after the first or second attack and had not "gone sick" for the later and comparatively slight recurrences.

The majority of cases were at first diagnosed

as *influenza*, though it was generally recognised by medical officers that they were not identical with the familar forms of that disease. Thus there is never any nasal or bronchial catarrh, the patient rarely appears or feels seriously ill, except sometimes during the first two days of the first attack, and respiratory and nervous complications never occur. The periodic return of pain and pyrexia and the pain and tenderness of the shins are quite characteristic and prevent confusion with influenza except at the onset.

The possibility of *malaria* must always be considered, and a blood film should be examined for the malarial plasmodium before making a definite diagnosis in cases of doubt, especially when it is prevalent, as was the case during the summer of 1916 in Salonica, or if the patient has previously had malaria. The differential leucocyte count is of no assistance, as there is a relative increase in large mononuclear cells in both diseases. The longer intervals between the attacks, their invariable occurrence in the evening instead of at various times of the day, the absence of true rigors and the failure of quinine, given by mouth, to modify the course of the illness are distinguishing features of trench fever. Several old soldiers at first thought that they were suffering from malaria, but they subsequently realised that the disease must be different, as they never before had had severe pain and tenderness in their shins.

A few cases of true *relapsing fever* occurred in British as well as Indian troops at Gallipoli, but only eight Indian and no British soldiers had been attacked by the disease in Salonica up to the end of April. The disease was, however, common in the Serbian Army in 1915, and was actually first described by Hippocrates in the Greek island of Thasos, so it is necessary to be on the look out for it among British as well as Indian soldiers at Salonica, and at least one case occurred in June, 1916. In six cases I saw with Captain F. F. Strother-Smith, I.M.S., the pyrexial period was generally longer, varying between 2½ and 6 days, and the fever was higher than in trench fever, the maximum temperature in each attack being between 104° and 105°·6; successive relapses did not diminish in severity unless they were cut short by injecting salvarsan, the effect of which was almost instantaneous, the patients were extremely ill and often delirious during the pyrexial periods, and the delirium occasionally continued after the temperature fell; bronchitis was common, and there was no pain in the legs nor tenderness of the shins; the apyrexial periods varied between two and eight days, six days being the most common, but the periodicity was less regular than in the periodic type of trench fever. The spirochæte was found without difficulty in the blood during the pyrexial period in every case. The disease may, however, be less severe when it occurs among Europeans.

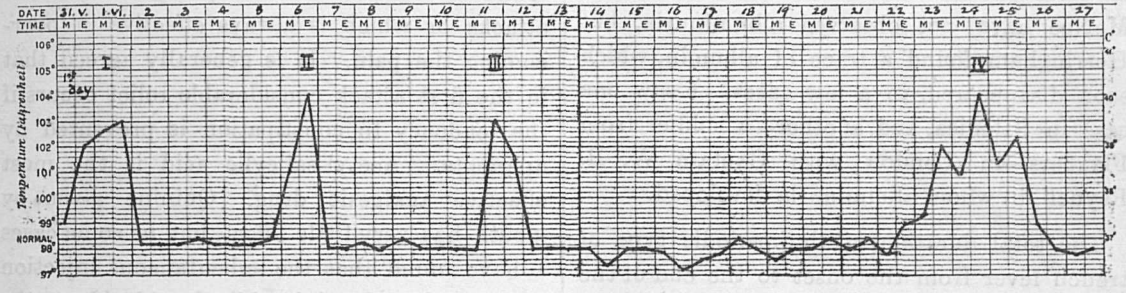


Chart VI.—Periodic form of Trench Fever. Third relapse (June 23-25) of exceptional duration and severity following an interval of double length.

Prognosis.—There have been no fatal cases and the patient never appears seriously ill, except occasionally for a very short time in the first attack.

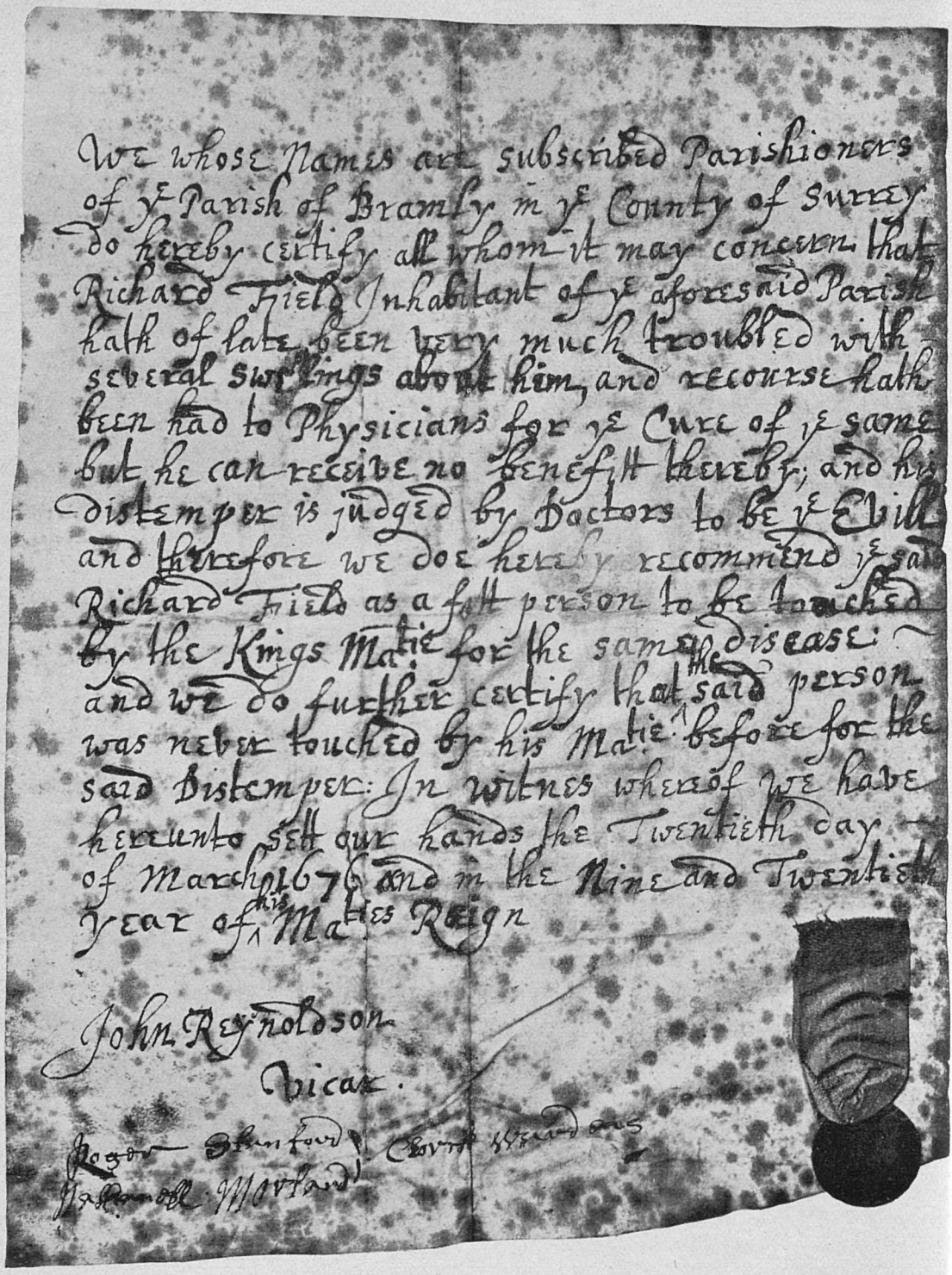
Until the commencement of the hot weather in Salonica at the end of May no complications had been observed with the exception of phlebitis of the femoral vein in one case, and slight jaundice in two cases, but the latter at any rate was probably accidental. With the onset of the hot weather it was found that trench fever was often accompanied by a moderate degree of cardiac dilatation, which resulted in the development of "soldier's heart" if the patient returned to full duty too soon. Endocarditis has never occurred. Hunt and McNee have not observed albuminuria, but Herringham found a trace of albumin, which soon disappeared, in a few cases. I saw one case in Salonica, and another—a soldier from Flanders—in London with Captain W. R. Reynell, in whom albuminuria developed.

The total duration of the periodic type of trench fever from the onset to the end of the last attack is generally between four and six weeks, but some cases appear to abort, and in a few others attacks may recur for several months, the patient remaining quite well in the intervals. I saw a sergeant with the periodic form of trench fever in January, 1916, in Salonica; he had had similar attacks at intervals since August, 1915, when he first became ill in France. In most cases the patient rapidly gets strong again after an attack and is generally fit for duty after the second period of pyrexia, though he may have to rest for a few hours when the later attacks occur. Sometimes, however, great exhaustion follows and convalescence is slow.

Prophylaxis.—As the disease is probably conveyed by lice, which become infected by biting a patient during an attack, every effort should be made to keep troops free from them. Allr cases of trench fever should either be sent to hospital or isolated, and the patient's clothes and bedding should be specially disinfected, as well as that of all men who have recently slept near him. After the initial or the second attack a man is often able to return to duty; it is very important that he should be kept under observation, and if he again becomes verminous his clothes and bedding should again be disinfected; men who are still having attacks or have recently recovered should sleep together, isolated from the other men in their unit, but there is no reason why they should not work with them.

Treatment.—No treatment has yet been found which prevents the periodic return of attacks or which is always effective in overcoming the pain. It is generally agreed that in the first attack considerable relief occurs if the tendency to constipation is prevented by aperients. Acetyl-salicylic acid is the most effective analgesic drug. Quinine given by mouth has very little effect, but in some cases I have found that the subcutaneous injection of ten grains of quinine bihydrochloride at the height of an attack, especially if it is repeated in three hours, appears to prevent the occurrence of relapses. Salvarsan and antimony have proved useless. In one severe case Hunt and McNee tried intravenous injections of eusol without success, and in two others 20 c.c. of the serum of a convalescent patient was injected intravenously without influencing the course of the illness.

Numerous local applications, both hot and cold, have been used for the painful shins; some of them have appeared to do good in certain cases, but the most frequently successful seems to have been a cold compress of saturated magnesium sulphate solution, which was first recommended by Captain D. S. Harvey. In slight cases gentle massage has given temporary elief, and I have seen a number of cases in



We whose Names are subscribed Parishioners
of ye Parish of Bramly in ye County of Surrey
do hereby certify all whom it may concern that
Richard Field Inhabitant of ye aforesaid Parish
hath of late been very much troubled with
several swellings about him, and recourse hath
been had to Physicians for ye Cure of ye same
but he can receive no benefitt thereby; and his
distemper is judged by Doctors to be ye Evill
and therefore we doe hereby recommend ye said
Richard Field as a fitt person to be touched
by the Kings Matie for the same disease:
and we do further certify that the said person
was never touched by his Matie before for the
said Distemper: In witnes whereof we have
hereunto sett our hands the Twentieth day
of March 1676 and in the Nine and Twentieth
year of his Maties Reign

John Reynoldson
Vicar.

Roger Stanford Clerk Wardens
Nathaniell Morland

For explanation of this Certificate see page 327.

which Captain W. R. Reynell has given galvanic baths for the legs with frequent renewals of the current with unexpectedly good results. In a few cases in Salonica the periosteum was incised, but when this was done on one side only, improvement occurred with equal rapidity on the opposite side. Even if the results had been more promising, I should regard the operation as quite unjustifiable, as the pain always disappears spontaneously in the course of a few weeks and often quite rapidly, even when it is exceptionally severe.

Appointments.

Royal Navy Medical Service.

The following appointments have been notified:—

Deputy Surgeon-General W. W. Pryn to be Surgeon-General.

Temporary Surgeons:—G. Hamilton, M.B., to the *Victory*, additional for Haslar Hospital. A. L. Punch, M.B., to the *Pembroke*, additional for Chatham Hospital. T. Norman to Leith Naval Hospital. B. Burnside to H.M.S. *Vindictive*.

Surgeon-Probationers:—E. M. Harrison to the *Weymouth*. G. L. Cutts from H.M.S. *Narwhal* to H.M.S. *Laertes*.

Royal Army Medical Corps.

Temporary Lieutenants to be temporary Captains:—J. E. Barnes, M.B., J. F. Young, F. O. Stohr, K. D. Smedley, J. Young, E. Huntley.

To be temporary Lieutenants:—J. H. Wilks, G. A. Ticehurst.

Capt. H. V. Leigh, M.B., from Welsh Regiment (T.F.), to be temporary Captain (substituted for notification in the *London Gazette* of May 3rd, 1915).

The following have been appointed Army Dental Surgeons with the rank of temporary Lieutenants:—S. G. Elliott, G. G. Ellis, J. M. Pomeroy, S. J. Saunders, L. P. Richards, L. W. Ward.

Royal Army Medical Corps (Territorial).

Scottish General Hospital:—Major H. Walker and Capt. A. Fraser are seconded for duty with a General Hospital.

Wessex Casualty Clearing Station:—Lieut. W. S. Richardson, F.R.C.S., to be Captain.

South Eastern Mounted Brigade Field Ambulance:—Capt. (Temporary Major) Frank Loud, Sussex R.G.A., to be Major (temporarily).

Northern General Hospital:—Captains seconded for duty with a Mounted Brigade Field Ambulance—Capt. F. Alcock, M.D.

A Recent Addition to Guy's Gazette Museum.

This Certificate was found by the late Mrs. Potter among some Title deeds of property belonging to the family of Field (of Smithbrook, in the parish of Bramley), descendants of the person to whom it refers.

In addition to the evidence it offers of the generally prevailing superstition at the period upon the efficiency of the "Touch," it is additionally curious and interesting as a testimony to the correctness of the opinion that Scrophula (*sic.*) is an hereditary disease—as the Field family is still liable to that disease.

The coin is a piece of the "Touch Money" which was presented by the Sovereign at the time of the ceremony, and afterwards worn suspended from some part of the afflicted person.

This particular piece has on one side a ship in distress with the legend:—Jacoii D.G. M.B. Er et HIB. REX., and on the other:—Gloria soli DEO.

Roll of Honour.

Died of Wounds.

Major A. Martin, New Zealand Army Medical Corps.

Wounded.

Capt. H. A. Pallant, R.A.M.C., (attached to the Loyal North Lancashire Regiment).

Lieut. S. J. Darke, R.A.M.C.

J. B. Dunning.

Honours.

Mentioned in Despatches.

EGYPT.

Capt. G. L. Eastes, R.A.M.C. (T.F.), 2nd London Sanitary Company.

SALONIKA.

Temporary Captain H. H. Davis, F.R.C.S., R.A.M.C.

An unusual Case of Small Intestine Obstruction.

A woman, Rose P., æt. 47 years, who enjoyed apparently unbroken good health up to the beginning of this year, suddenly began to experience increasing pain, vomiting, diarrhœa, and finally absolute obstruction within the space of four months.

At the end of April of this year the patient noticed a very slight flitting pain in the left hypochondrium. During the following six weeks there were no other symptoms, but the pain gradually increased in intensity and duration and had no relation to her meals or her posture. Now, quite suddenly, patient began to vomit; she was unable to retain any food, but an interval elapsed between the meal and its return, during which she experienced considerable discomfort. The vomit contained neither blood nor mucus, but was coloured with bile. With the onset of vomiting there ensued a persistent diarrhœa (six times daily), the stools being offensive, frothy, and brown.

After a fortnight (four weeks before admission), patient noticed that her abdomen was more prominent than usual and that irregular "knots" were continuously appearing and moving over its surface. The presence of these "knots" determined the onset of attacks of pain, but did not affect the vomiting or diarrhœa; cutaneous stimulation easily caused the appearance of the phenomenon. The condition became progressively worse until a day (two days before admission) when the bowels suddenly ceased to act; vomiting increased, the "knots" ran continuously, and the pain became acute.

On admission into Charity, patient was seen to be emaciated and certainly in great pain; her abdomen was greatly distended to a shape resembling an inverted pudding-basin, and on its surface there was visible peristalsis running in various directions. Palpation showed that the abdomen was tender, tense, and contained no obvious tumour; the pulse was 96, rising during the following seven hours to 115; the temperature was 99·4° and the respirations 20. During the afternoon patient vomited more or less continuously, and a turpentine enema elicited a fairly copious fæcal result. Mr. Tanner saw patient and diagnosed small intestinal obstruction.

On opening the abdomen, the small intestine was found greatly distended and the large bowel collapsed, and, about 12 inches from the ileo-cæcal valve, the ileum was obstructed by a tight annular constriction, which completely obliterated its lumen and did not appear to have infiltrated the tissues around. There was no enlargement of glands anywhere and the liver was apparently normal. Mr. Tanner performed a lateral anastomosis between portions of the ileum immediately above and below the obstruction.

During the night following the operation the patient passed much flatus and her abdomen became supple and practically free from pain. An aperient was given on the third day, and paraffin then ordered. On the fifth day the pulse and temperature reached normal and continued so until patient was discharged.

It is suggested that the obstruction was due to cicatrisation of a healed tuberculous ulcer at that spot.

J. V.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the Gazette *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

GUY'S HOSPITAL ROLL OF WAR SERVICE.

1.—Medical School and Staff (Past and Present).

Ackroyd, H.	Temp. Capt. ...	R.A.M.C.
Adams, D. W. S. ...	Private ...	South African Gen. Hosp.
Adams, F. S.	Temp. Lieut. ...	R.A.M.C., 1st West Riding F.A.
Adams, M. M. ...	Temp. Lieut. ...	R.A.M.C.
Adams, R. R.	Tp. Dent. Surg.	R.N.V.R., H.M.S. "Thunderer."
Alcock, Frank	Capt.	R.A.M.C. (T.F.).
Alcock, J. A. M. ...		
Aldis, C.	Temp. Capt. ...	R.A.M.C. (20th F.A.), No. 10 Stationary Hospital.
Alexander, S. R. ...		Div. Surg., V.A.D. Hospital, Faversham.
Allan, A. P.		M.O. in charge Wallacefield Conv. Home for Wounded Soldiers.
Allan, D.	Temp. Lieut. ...	R.A.M.C.
Allan, W. J. McB. ...	Surg. Prob. ...	H.M.S. "Mallock."
Allen N.		
Allen, R. W.		Special service at Hôpital Militaire, V.R. No. 76.
Allen, T. S.	Temp. Capt. ...	R.A.M.C., No. 12 Gen. Hosp., B.E.F.
Allport, A.		Civil Surgeon attached to R.A.M.C.
Alston, W. Evelyn ...	Major	R.A.M.C. (T.F.).
Anderson, R. G. ...	Major	R.A.M.C.
Anderton, J. E. ...		M.O., New Mills V.A.D. Red Cross Hosp.
Andrew, G. W. ...	Capt.	R.A.M.C. (T.F.).
Andrews, E. G. ...	Capt	R.A.M.C. (T.F.), Cornwall R.G.A.
Andrews, G. Genge ...	Lieut.	R.A.M.C., M.O., 32nd Reserve.
Andrews, J. A. ...	Temp. Capt. ...	R.A.M.C. (*Mentioned in despatches*).
Andrews, R. C. ...		
Annesley, F. D. ...	Capt.	R.A.M.C., 25th Brigade R.F.A., 1st Division
Annis, E. G.	Capt.	R.A.M.C., O.C. 7th Provl. Field Ambulance.
Anthony, A. L. ...	Capt.	R.A.M.C. (S.R.).
Ashby, E.	Temp. Lieut. ...	R.A.M.C.
Ashwell, H. G. ...	Tp. Lieut.-Col.	R.A.M.C.
Ashwin, R. H. ...	Temp. Capt. ...	R.A.M.C.
Aspinall-Stivala, R. ...	Lieut.	
Atkins, John	Temp. Col. ...	R.A.M.C. (Mentioned in despatches; C.M.G., 1916.)
Atkinson, C. H. ...	2nd Lieut. ...	R.F.A.
Atkinson, J. L. ...	Temp. Lieut. ...	R.A.M.C.
Atkinson, N. M. H. ...		Late R. Fusiliers (Sergt.). (Cadet at Oxford, waiting commission).
Attwater, H. L. ...	Temp. Capt. ...	R.A.M.C.
Attwood, R. D. ...	Temp. Lieut. ...	R.A.M.C.
Aubrey, H. P. ...	Capt.	R.A.M.C.
Aylen, G. H.		Civ. Den. Surg. to troops, Portsmouth.
Badcock, G. W. ...	Private ...	3rd Batt. Sussex Vol. Regt.
Badcock, J. H. ...		Dent. Surg. to Red Cross Hosp. for Facial Injuries.
Bagshawe, H. V. ...	Major	R.A.M.C., D.S.O. (Mentioned in despatches.)
Bailey, E. R.	Surg.	R.N.
Bainbridge, F. A. ...	Temp. Capt. ...	R.A.M.C.
Baker, A. de Winter ...		Res. Anæsthetist, County of London War Hospital, Epsom.
Ball, Malcolm ...	Lieut.	R.A.M.C. (*Died of wounds, Mesopotamia, 10th April, 1916.*)
Ballard, R. P. ...	Capt.	R.A.M.C. (S.R.), 46th F.A.
Bankart, A. R. ...	Fleet Surg. ...	R.N., C.V.O.
Barber, H. W. ...	Lieut.	R.A.M.C.
Barge, H. F.	Private ..	London Scottish.
Barker, F. A.	Capt.	I.M.C., 100 Indian Field Amb.
Barker, H. T.	2nd Lieut. ...	Devon Regt.
Barlow, N. A. H. ...		
Barnes, F.	Capt.	R.A.M.C.
Barnes, J. E.	Temp. Lieut. ...	R.A.M.C. (*Mentioned in despatches.*)
Barnes, J. Millard ...	Capt.	R.A.M.C. (Dental)
Barnett, E. P. ...		Dent. Surg. to Red Cross Hosp., Cheltenham.

Barrand, H. J.	2nd Lieut.	Leicesters. (Wounded.)
Barrett, A.	Temp. Lieut.	R.A.M.C.
Barron, R. M.	Major	I.M.S., 113th Indian F.A. (Mentioned in despatches.)
Barrow, R. P. W.	Lieut.-Col.	R.A.M.C.
Barrow-Clough, W. J.	Surg.	R.N.
Barrs, A. G.	Tp. Lieut.-Col.	R.A.M.C. (T.F.).
Bartlett, C. E.	Lieut.	R.A.M.C., 52nd Heavy Artillery Group.
Bastard, H. R.	Surg.	R.N., H.M.S. "Otway."
Batsford, John F.	Lieut.	1/4th Batt. The Essex Regt. (T.F.). (Wounded at Suvla Bay Gallipoli, August, 1915.)
Baxter, C. W. W.	Lieut.	I.M.S.
Baylis, Paxton	2nd Lieut.	R.N.V.R.
Beadel, A. J.	Temp. Lieut.	R.A.M.C.
Beadnell, C. M.	Fleet Surg.	R.N.
Beadnell, H. D. M.	Major	R.A.M.C.
Bearblock, W. J.	Fleet Surg.	R.N. (Medal for Falkland Is. Battle. Killed in action, H.M.S "Invincible.")
Beard, F. G. V.		(Killed in action in France, July, 1916.)
Beley, G.	Temp. Capt.	R.A.M.C.
Bell, A.		Hon. Dent. Surg. to Queen Mary's Auxy. Hosp., Roehampton.
Bennett, J.		V.T.C. Musketry Instructor, Minehead.
Bennett, T. I.	Temp. Capt.	R.A.M.C., C.C.S.
Bensted, L.	Temp. Lieut.	R.A.M.C.
Bensted, M. W.	Temp. Lieut.	R.A.M.C., No. 30 Stationary Hosp.
Bent, P. C. W.	Temp. Lieut.	R.A.M.C.
Bent, S. C. H.	Temp. Lieut.	R.A.M.C.
Bent, V. T. C.	Temp. Lieut.	R.A.M.C.
Berncastle, H. F. G.	Lieut.	3rd Bedfordshire Regt. (Signalling officer, 3 months.)
Berncastle, P.		1st Batt. Bedfordshire Regt., B.E.F.
Berry, A. W.	Capt.	R.A.M.C., 2/3rd E. Lancs. F.A.
Berry, F. S. D.	Temp. Capt.	S.A.M.C., 3rd South African F.A. (German East Africa.)
Berry, H. Poole	Major	R.A.M.C., Regtl. M.O. 4th Batt. Lincs.
Berry, P. H.	Lieut.	R.A.M.C., Western Frontier Force, Egypt. (Drowned in attempting to save another man.)
Bett, W.	Fleet Surg.	R.N., M.V.O.
Bevan, A. H.		
Bevan-Brown, F. V.	Capt.	R.A.M.C. (Wounded.)
Beven, Octavius		M.O., 3rd H.A.C.
Bevers, E. C.	Capt	R.A.M.C. (T.F.), Southern General Hosp.
Bevis, D. A.	2nd Lieut.	Hants R.E. (T.F.).
Bevis, S. W.	Temp. Lieut.	R.F.A.
Biddle, E.	Temp. Lieut.	R.A.M.C., 91st F.A.
Biddle, F. J.	2nd Lieut.	1st Welsh Regt.
Bidwell, L.	Fleet Surg.	R.N., H.M.S. "Marmora."
Biggs, J. J. E.	Capt.	R.A.M.C.
Billing, E.	Temp. Capt.	R.A.M.C., No. 1 General Hosp.
Bird, J. W.	Lieut.-Col.	R.A.M.C., 6th London F.A. (D.S.O.).
Birks, A. H.	Temp. Capt.	R.A.M.C. No. 37 C.C.S.
Bishop, C. A. D.		
Blachford, J. V.	Tp. Lieut.-Col.	R.A.M.C., Beaufort War Hospital, Bristol.
Black, J.	Temp. Lieut.	R.A.M.C.
Black, K.	Temp. Lieut.	R.A.M.C.
Blackler, H. J.	Capt.	R.A.M.C.
Blake, E. W.	Temp. Capt.	R.A.M.C., 18th C.C.S., B.E.F.
Blake, G. A.	Capt.	R.A.M.C., Peshawar.
Bligh, W.	Temp. Lieut.	R.A.M.C.
Body, T. H.	Temp. Capt.	R.A.M.C., 4th Group Heavy Artillery.
Boland, E. A.		
Bolus, H. B.		Asst. Q.M., V.A.D., Kent (4).
Bolus, P. R.	Capt.	Asst. Q.M., V.A.D., Kent 41.
Bookless, J. S.	Temp. Capt.	R.A.M.C., Ophth. Specialist at Havre.
Boswell, P. R.	Capt.	R.A.M.C. (Wounded.)
Bouic, J. A.	Private	Artists' Rifles.

Bowen, O.	Temp. Capt. ...	R.A.M.C.
Bowen, W. H.		Hon. Asst. Surg. to Research (Officers') Hosp., Cambridge.
Bowle, S. C.	Major	R.A.M.C.
Bradbury, J. C. O. ...		M.O. in charge Helena Hosp., Shorncliffe.
Bradnack, G. A. ...		
Bradnam, C. H. ...		2nd Air Mechanic, Royal Flying Corps.
Brailey, A. R. ...	Staff Surg. ...	R.N., Haslar Hosp.
Brailey, W. H. ...	Major	A.S.C. (M.T.). (Cons. Ophth. Surg., General Hosps. for Indian troops.)
Braithwaite, J. ...	Temp. Lieut. ...	R.A.M.C.
Brereton, F. S. ...	Temp. Major ...	R.A.M.C.
Brett, W. G.	Temp. Capt. ...	R.A.M.C., Officers' Hosp., Tidworth.
Brewer, C. H.	2nd Lieut. ...	Bedford Regt.
Bridger, R. D. ...	Temp. Capt. ...	R.A.M.C.
Brodrick, C. C. ...		Surg., Warwick Regt.
Bromley, L.		Civil Surgeon, Southwark Military Hosp.
Broster, L. R.	Lieut.	R.A.M.C., 34th F.A., 31st Brigade, 14th Division.
Brounfield, H. M. ...	Lieut.-Col. ...	R.A.M.C. (T.F.), in charge Red Cross Hosp., East Liss.
Brown, C. M.	Temp. Lieut. ...	R.A.M.C.
Brown, G. M.	Temp. Capt. ...	R.A.M.C.
Brown, H. S.	Temp. Surg. ...	R.N., Plymouth Hosp.
Brown, R. T.	Major	R.A.M.C., East African Force. (Mentioned in despatches.)
Brown, T. F.	Capt.	R.A.M.C., 1st Australian General Hosp.
Browne, E. Gardner ...		
Browne, Robley H. J.	Fleet Surg. ...	R.N.
Browne, W. Denis ...		R.N.V.R. (Killed in action, June 7th, 1915.)
Browne-Carthew, R. H.		Physician to Brook War Hosp.
Browning, S. H. ...	Temp. Capt. ...	R.A.M.C.
Bruce, H. W.	Temp. Major ...	R.A.M.C., in charge Southwark Military Hosp.
Brumwell, G. N. ...	Surg.-Col. ...	V.D. (Retired.)
Bryant, C. H.	Temp. Capt. ...	R.A.M.C., Surg. to Hove Red Cross Hosp.
Bryant, E. H.		
Buchanan, A.	Tp. Hon. Lieut.	R.A.M.C.
Buchanan, A. G. ...	Capt.	R.A.M.C. (T.F.), Lowland F.A.
Buck, A. D.	Tp. Civ. Dent. Surg. ...	R.N., Royal Marine Infy., Deal.
Buckeridge, G. L. ...	Staff Surg. ...	H.M.S. "Haleyon."
Bulleid, Arthur ...	Sergeant ...	Artists' Rifles.
Bullpitt, C. M. ...		
Burgess, E. A. ...	Tp. Civ. M.O....	3/8th Lancashire Fusiliers.
Burgess, W. T. R. ...	Tp. Civ. Surg...	Military Hospital, Preston, Brighton.
Burghard, F. F. ...	Temp. Col. ...	R.A.M.C., C.B. (Mentioned in despatches.)
Burney, W. H. S. ...	Capt.	R.A.M.C. (Mentioned in Despatches.)
Burnside, B.	Temp. Surg. ...	R.N., Royal Naval Hosp., Haslar, Gosport.
Burton, A. G. H. ...	Temp. Lieut. ...	R.A.M.C.
Burvill-Holmes, L. ...		
Busteed, J. H.		M.O., All Hallows' Hosp., Ditchingham.
Butler, H. R. C. ...		Dent. Surg., V.A.D. Hosp., Tiverton.
Cade, C. R.	Surg. Prob. ...	H.M.S. "Dido."
Cameron, J. ...	Temp. Lieut. ...	R.A.M.C., T. Surg., Haslar Hosp.
Campbell, H. J. ...		Civil M.O., Bradford War Hosp.
Campbell, J. M. H. ...	Lieut.	R.A.M.C.
Campian, J. H. ...	Temp. Capt. ...	R.A.M.C.
Campion, R. B. ...	Capt	R.A.M.C. (S.R.), O.C., Dental Annexe, Alexandria.
Campkin, P. S. ...		Hon. Dent. Surg. to Lord Knutsford's Hosp. for Officers and Lady Somerleyton's Hosp.
Camps, P. W. L. ...	Temp. Lieut. ...	R.A.M.C.
Cardin, H.		Civil Surgeon, 11th Battn. Loyal North Lancs.
Carlill, H. B.	Temp. Surg. ...	R.N., Neurologist, R.N. Hosp., Haslar.
Carr, T. E. A. ...	Capt.	R.A.M.C. (T.F.), 1st F.A., 5th Divn.
Carter, A. H.	Temp Major .	R.A.M.C.
Carter, A. J.	Commandant ...	M.O. in charge Auxiliary Military Hosp.
Carter, H. H.	Temp. Capt .	R.A.M.C.

Carter-Braine, J. T. ...	Sergeant ...	R.A.M.C. (T.F.), 2nd London C.C.S.
Cartridge, A. A. M. ...		Sutton Red Cross Hosp.
Cattell, G. T.	Lieut.-Col. ...	Commandant, Prisoners of War, Rouen.
Chadwick, G. R. ...		Admiralty Surgeon and Agent.
Chadwick, Morley ...	Lieut.	R.A.M.C.
Chaning-Pearce, W. T.	Capt.	R.A.M.C., 96th F.A., B.E.F.
Chapman, P. D. N. ...	Temp. Lieut. ...	R.A.M.C.
Chapple, H.		Surg. to Fulham Military Hosp. and Royal Flying Corps' Hosp.
Charles, G. F.	Lieut.	R.A.M.C. (Dental).
Charles, S. W. ...	Lieut.	R.A.M.C. (In East Africa.)
Chase, R. G.	Temp. Lieut. ...	R.A.M.C., Base Hosp., Calais.
Cheesman, A. E. P. ...	Surg	R.N., H.M.S. "Pembroke."
Child, Stanley	Lieut.	R.A.M.C. (T.F.), South Wales Mounted Brigade F.A.
Chubb, W. L.		M.O., 10th Hants V.A.D.
Churchill, G. B. F. ...	Major	R.A.M.C.
Clark, A. E.	Temp. Lieut. ...	R.A.M.C.
Clark, A. J.		
Clark, J. B.	Capt.	R.A.M.C.
Clark, W. F.	Temp Capt. ...	R.A.M.C.
Clarke, A. E.	Temp. Lieut. ...	R.A.M.C.
Clarke, A. V.	Colonel ...	A.M.S. (T.F.).
Clarke, Geoffrey ...	Temp. Capt. ...	R.A.M.C.
Clarke, Kenneth ...	Capt.	R.A.M.C. (Invalided out.)
Clarke, H. M.	Capt.	R.A.M.C., H.M.H.S. "Aquitania."
Clatworthy, J. H. ...		Civil Surg., 4th London General Hosp.
Cleveland, A. J. ...	Temp. Major ...	R.A.M.C., Norfolk War Hosp.
Clewer, D	Capt.	R.A.M.C. (D), Senior Dental Officer, 2/2nd London C.C.S., 4th Army.
Clifford, A. C.	2nd Lieut. ...	3rd Dragoon Guards. (Killed in Action, Ypres, June 1st, 1915.)
Clough, A. H.	Temp. Lieut. ...	R.A.M.C.
Clowes, E. F.	Temp. Capt. ...	R.A.M.C., 50th F.A., B.E.F.
Clowes, N. B.	Capt.	R.A.M.C. (T.F), 3rd Southern General Hosp.
Cocking, A. W. ...		
Cockrem, G. B. ...	Surg.	R.N., H.M.S. "Vivid."
Cocks, J. Stanley ...	Capt.	R.A.M.C.
Coffin, S. W.	Temp. Capt. ...	R.A.M.C.
Cogan	Capt	R.A.M.C., 88th F.A.
Cole, P. P.	Temp. Lieut. ...	R.A.M.C., 1st Southern General Hosp.
Cole, T. P.	Temp. Capt. ...	R.A.M.C.
Coleman, E	Temp. Capt. ...	R.A.M.C.
Coleman, J. G. H. ...	Temp. Lieut. ...	R.A.M.C.
Collar, F.	Capt.	East African Medical Service. (Invalided home.)
Collier, H. N.	Capt	R.A.M.C., Welsh F.A.
Collins, H. Abdy ...	Commandant ...	6th Batt. Suffolk Volunteer Regt.
Collins, M. Abdy ...	Temp. Capt. ...	R.A.M.C.
Collis, A. J.	Lieut.-Col ...	Northern Cyclist Batt. (T.F.).
Constant, C. F. ...	Temp. Capt. ...	R.A.M.C.
Conybeare, J. J. ...	Capt.	4th Batt. Oxford and Bucks., B.E.F.
Cook, John	Capt.	R.A.M.C., 268th Brigade R.F.A.
Cooke, E. J.	Temp. Surg. ...	R.N., Royal Naval Hospital. (H.M.S. "Alsatian.")
Cookes, R. V.	2nd Lieut. ...	10th Staffordshire Regt.
Cooper, C. M.	Lieut.	R.A.M.C. (T.F.), North Midland F.A.
Cooper, H.		M.O. Oakenshaw Military Hosp., Kingston and Surbiton Military Hospitals.
Cooper, T. P.	Dental Surg. ...	R.N.
Coplans, M.	Capt.	R.A.M.C. (T.F.), 3rd County of London F.A. (Twice mentioned in despatches.)
Corfe, E. W.		Hon. Dent. Surg. to V.A.D. Hosp., East Finchley.
Corin, H. J.	Dental Surg. ...	R.N.V.R. Cons. Dent. Surg to Belgian Field Hosp., Fiernes
Costabadie, H. P. ...	Temp. Lieut. ...	R.A.M.C. (Mentioned in despatches.)
Costabadie, V. A. P. ...	Capt.	R.A.M.C. (T.F.).
Cowper, C. M.	Capt	R.A.M.C., 2nd North Midland F.A.
Cotton, H.	Capt.	R.A.M.C. (retired).

Counsell, H. E.	Major	R.A.M.C. (T.F.), 3rd S. Base Hosp., Oxford.
Cousins, B. P.		
Covell, G.	Lieut.	I.M.S., 139th Indian F.A., East Africa
Coventry, C.	Temp. Capt.	R.A.M.C.
Cox, A. Neville	Lieut.	R.A.M.C., Tubercle Specialist, Kitchener Hosp., Brighton.
Coxon, A. C. M.	Capt.	5th Norfolks. (Wounded and prisoner, Dardanelles, 1915.)
Craig, R. N.	Lieut.	R.A.M.C., 136th F.A.
Crawford, V. J.	Lieut.-Col.	R.A.M.C., D.S.O.
Crawford	Lieut.	R.A.M.C.
Creasy, R.		Surg. British Red Cross Unit for Italy. No. 1 Hosp.
Creasy, R., jr.	Surg.	R.N. H.M.S. "Royal Oak."
Cresswell, F. P. S.		Ophth. Surg. to Welsh Metropolitan War Hosp.
Crew, F. D.	Temp. Lieut.	R.A.M.C.
Crocker, C. J.	Temp. Lieut.	R.A.M.C.
Crofts, A. D		M.O. to 4th Res. Batt. Coldstreams.
Crook, A. H.	Surg	R.N.V.R., 2nd F.A., R.N. Divn.
Crook, F. W.	2nd Lieut.	2nd K.R.R.
Crosse, Spencer S.	Capt.	R.A.M.C., Royal Welsh Fusiliers.
Crowe, A. A. R.		
Curle, R.	Lieut.	R.A.M.C.
Currie, D. J.	Lieut.-Col.	S.A.M.C., A.D.M.S., No. 1 and No. 14 Districts, South Africa.
Curtis, F.		Surg., Abbotts' Hosp. and Reigate and Redhill Hosp. for Wounded Soldiers.
Cushing, R. J. W.	Capt.	R.A.M.C. (T.F.), 2nd London General Hosp.
Cutler, F. J.		Civil Surg., Military Hosp., Pembroke Dock.
Cutler, H. A.	Temp. Capt.	R.A.M.C.
Cutts, G. L.	Prob. Surg.	R.N.V.R.
Dakin, W. K.	Tp. Med.-Major	French Army.
Daldy, A. M.	Capt.	R.A.M.C., Ophth. Surg., 2nd Eastern General Hosp.
Daldy, Mantell	Temp. Capt.	R.A.M.C.
D'Alton, Mark	Temp. Pte.	Motor Batt. L.V. Rifles.
Danby, A. B.	Lieut.	*Monitor* 18.
Davidson, A.	Temp. Lieut.	R.A.M.C.
Davidson, G. G.		Militia Hosp., Queen's Gate.
Davies, A. H.	Temp. Lieut.	R.A.M.C.
Davies, G.		
Davies, J. C.	Capt.	R.A.M.C., 34th Divn. R.E.
Davies, John W.	Lieut.-Col.	R.A.M.C., 1st Welsh F.A.
Davies, L. G.	Temp. Capt.	R.A.M.C., M.O., 33rd Batt. R.F.
Davies, W. L. C.	Temp. Capt.	R.A.M.C., 3rd Batt. King's Liverpool Regt.
Davies-Colley, H.	Temp. Lieut.	R.A.M.C.
Davies-Colley, R.	Major	R.A.M.C.
Davis, H. H.	Temp. Capt.	R.A.M.C., York and Lancs. Regt.
Davy, H.	Lieut.-Col.	R.A.M.C., Cons. Physician, Southern Command
Daw, S. W.	Capt.	R.A.M.C., in charge, Orthopœdic Dept., Northern Command.
Dawe, C. H.	Staff Surg.	R.N., H.M.S. "Pembroke."
Dawson, E. A.	2nd Lieut.	Somerset Light Infantry. (Wounded.)
Day, F. W.		
Day-Lewis, A. K.	Lieut.	West Yorks. Regt.
Dean, L. T.	Temp. Capt.	R.A.M.C.
Delmege, J. A.	Temp. Capt.	R.A.M.C.
Denman, R.	Temp. Capt.	R.A.M.C.
Dennett, F. J. C.		
Dennett, P.	Trooper	Surrey Yeomanry, 29th Divn.
Denning, A. F. W.	Temp. Lieut.	R.A.M.C.
Denny, H. R. H.	Fleet Surg.	R.N.V.R.
Denyer, S. E., C.M.G.	Sanitary Officer	H.Q. Staff, Humber Garrison.
Depree, H. T.	Temp. Surg.	R.N.
Dick, F. A.	Temp. Lieut.	R.A.M.C., 2nd London Clearing Station.
Dickey, W. C. McN.	Temp. Capt.	R.A.M.C.
Dickson, A. C.	Temp. Lieut.	R.A.M.C.
Digby, W. E. S.		West African M.S. (Mentioned in despatches.) (Cameroons.)

Dinan, Geo. A.	2nd Lieut.	...	Royal Dublin Fusiliers. (Killed in action, 9th September, 1916.)
Dingley, W.			
Dix, C. B.			
Dixon, J.	Temp. Capt.	...	R.A.M.C.
Dodd, H. G.	Capt.	...	R.A.M.C. (T.F.), 315th Battery R.F.A.
Dodd, W. H.			Recruiting M.O. for Wimborne District.
Doll, H. W.	Temp. Capt.	...	R.A.M.C., 17th General Hosp., Alexandria.
Domville, E. J.	Tp. Lieut.-Col.	..	R.A.M.C.
Donn, R. L.	Temp. Lieut.	..	R.A.M.C., Army Dental Surg.
Donnell, J. H.	Capt.	...	R.A.M.C. (T.F.).
Dorward, C. D. M.	2nd Lieut.	...	14th Royal Sussex Regt.
Douglas, Chas. Gordon	Capt.	...	R.A.M.C. (Military Cross. Mentioned in despatches.)
Dowling, C. B.	Private	...	King Edward's Horse.
Dowsett, E. B.	Temp. Col.	..	R.A.M.C., Asst. Director for Medical Services, 2nd London Divn.
Drake, G. H.	Temp. Lieut.	...	Canadian A.M.S.
Dresing, H. G.	Temp. Capt.	...	R.A.M.C.
Drew, Hy. W.	Temp. Capt.	...	R.A.M.C.
Drew, Vincent	2nd Lieut.	...	9th Duke of Cornwall's Light Infantry.
Dring, W. E.			M.O. in charge Kent. Batt. (1/7th Devons.)
Druitt, D. C.	Temp. Lieut.	...	R.A.M.C.
Dryland, G. W.	Temp. Lieut.	...	R.A.M.C.
Duff, R. M. K.			
Duke, E.	Temp. Capt.	...	R.A.M.C.
Duke, Joshua			R.A.M.C.
Duke, Lyndhurst			R.A.M.C.
Dunbar, C. G.	Temp. Lieut.	..	R.A.M.C. (Mentioned in despatches.)
Duncan, G. E.	Fleet Surg.	...	H.M.S. "Europa."
Dunderdale, Geoffrey			East African M.S.
Dunning, J. B.	Temp. Lieut.	...	R.A.M.C., 13th Royal Sussex.
Dunstan, R.			M.O. to troops, Paignton.
Dutton, Thos.			Civil Surg., Hammersmith Battn.
Dymott, G. L	Major	...	281st Battery R.F.A.
Eager, R.	Temp. Major	...	R.A.M.C., Wessex F.A.
Eagleton, A. J.	Temp. Capt.	...	R.A.M.C.
Eason, H. L.	Lieut.-Col.	...	R.A.M.C., Mediterranean Expeditionary Force.
Easter, W. A.	Lieut.	...	R.A.M.C., 68th F.A.
Eastes, E. L.	Temp. Capt.	...	R.A.M.C., O.C. 24th Sanitary Section.
Eastes, G. L.	Lieut.	...	2nd London Sanitary Co.
Easton, W. A.	Temp. Capt.	...	R.A.M.C., 68th F.A.
Eaton, O.	Temp. Capt.	...	R.A.M.C.
Eccles, G. D.	Temp. Capt.	...	R.A.M.C. (Brit. Exped. Hosp., B. Lahore Divn., India.)
Eccles, H. D	Capt.	...	R.A.M.C., M.O. 13th Royal Irish Rifles.
Eccles, H. N.	Lieut.	...	R.A.M.C.
Eddison, H. W.			
Edey, F. H.	Capt.	...	A.S.C. (In Mesopotamia.)
Edey, G. Russell	Lieut.	...	R.A.M.C.
Edey, T. H.	Temp. Lieut.	...	R.A.M.C.
Edgar, N.			Hon. Dent. Surg., V.A.D. Hosp., Enfield.
Edmond, J.	Temp. Lieut.	...	R.A.M.C., No. 11 General Hosp., B.E.F.
Edney, C H			
Edwards, C. D	Temp. Capt.	...	R.A.M.C., 74th Sanitary Section, B.E.F.
Edwards, C. H.	Lieut.	...	R.A.M.C. (T.F.), War Hosp., Norbury.
Edwards, F.			M.O. to V.T.C. (South London Regt.).
Eglington, D. C.			
Ehrlich, H. A.	Capt.	...	R.A.M.C., 2nd Hampshires.
Elkington, Geo.	Temp. Capt.	...	R.A.M.C.
Elkington, G. W.			
Elliott, H. H.	Temp. Capt.	...	R.A.M.C., 8th Welsh (Pioneers). (Wounded.)
Elliott, E. L.	Temp. Surg.	...	R.N., H.M.S. "Karapara."
Elliott, H. G.	Temp. Lieut.	...	R.A.M.C. (Dental).
Elliott, S G.	Temp. Lieut.	...	R.A.M.C. (Dental).
Ellis, G.	Temp. Lieut.	...	R.A.M.C.
Ellis, J. S.			

Elmwood, Herbert ...		Dent. Surg. to L'Hôpital de l'Alliance, Yvetot.
Elwood, W.	Temp. Capt. ...	R.A.M.C.
Endean, F. C.	Surg.	H.M.S. "Vivid."
Enice, J. W.	Temp. Capt. ...	R.A.M.C.
Ensor, C. A.	Capt.	R.A.M.C., Poona, India.
Ensor, John		Surgeon, Golder's Green Auxiliary Hosp.
Eskell, P. R.	Temp. Lieut. ...	R.A.M.C.
Etches, W. R. ...	Temp. Capt. ...	R.A.M.C.
Evans, C. R.	Lieut.-Col. ...	R.A.M.C. (D.S.O.)
Evans, Ed.	Lieut.	R.A.M.C.
Evans, Evan	Temp. Capt. ...	R.A.M.C.
Evans, E. A.	Temp. Capt. ...	R.A.M.C.
Evans, E. G.	Lieut.	R.A.M.C.
Evans, H. W.	Capt.	R.A.M.C. (S.R.).
Evans, J.	Lieut.-Col. ...	R.A.M.C. (T.F.), in charge Welsh F.A.
Evans, J. A.		
Evans, J. E. Rhys ...		Killed in action, Dardanelles.
Evans, L. W.	Temp. Capt. ...	R.A.M.C., 9th East Lancs.
Evans, Rd.		In charge, Red Cross Hosp., Croxley Green.
Evans, T. G.	Capt.	R.A.M.C., Canadian A.M.C.
Evans, T. Garfield ...	Temp. Lieut. ...	R.A.M.C., 34th Welsh General Hosp.
Every-Clayton, L. E. V.	Temp. Capt. ...	R.A.M.C.
Ewen, H. W.		X-ray and Electrical Therapeutics at Isle of Wight War Hosps.
Eyleton, A. T.	Temp. Capt. ...	R.A.M.C.
Fagge, C. H.	Temp. Hon. Lieut.-Col. ...	R.A.M.C., Hampstead Military Hosp.
Fagge, R. H.	Capt.	R.A.M.C., 1/5th Northern Hosp.
Falwasser, A. T. ...	Lieut.-Col. ...	R.A.M.C. (T.F.), C.O., 2/1st Home Counties F.A.
Farrington, R. G. ...	2nd Lieut. ...	R.F.A.
Farrington, W. B. ...	Lieut.	3rd Sherwood Foresters.
Fasken, N. E.	2nd Lieut. ...	Royal Marine Artillery.
Faulks, Edgar	Lieut.	R.A.M.C. (Died in France, September 27th, 1915.)
Fawcett, F. W. ...	Temp. Capt. ...	R.A.M.C.
Fawcett, John	Capt.	R.A.M.C., 2nd London General Hosp.
Fawcus, D. A.	Temp. Lieut. ...	R.A.M.C., No. 37 C.C.S.
Fawssett, F. W. ...	Temp. Capt. ...	R.A.M.C.
Featherstone, F. R. ...	Temp. Lieut. ...	R.A.M.C. (Late Surg. R.N.)
Featherstone, J. W. ...	2nd Lieut. ...	Worcester Yeomanry.
Fell, R.	Temp. Capt. ...	R.A.M.C., M.O. H.M. Hosp. Ship "Egypt."
Felton, R.	Temp. Lieut. ...	R.A.M.C., M.O. 17th Middlesex, 33rd Divn. (Wounded.)
Feoo, R.	Temp. Capt. ...	
Fisher, H. Wycliffe ...	Capt.	R.A.M.C., Indian E.F.
FitzGerald, A. H. ...	Temp. Lieut. ...	R.N.V.R.
Fitzgerald, G. H. ...		
Flower, N.		Hon. Surg. Yeovil Red Cross Hosp.
Floyd, Walter	Capt.	S.A.M.C. (Dental). (In East Africa with Smut's forces.)
Forrest, A. G.	Temp. Lieut. ...	R.A.M.C. (Dental).
Forty, A. A.	Temp. Lieut. ...	R.A.M.C., 2nd Northern General Hosp., Leeds.
Foster, R. H.		Res. Surg., 2nd Birmingham War Hosp.
Foster-Smith, G. T. ...	Lieut.	R.A.M.C., 19th General Hosp., Alexandria.
Fothergill, C. T. ...	Temp Lieut. ...	R.A.M.C. (Served in Mediterranean.)
Fothergill, E. Rowland	Temp. Capt. ...	R.A.M.C.
Fouraker, L. F. ...		
Foulston, E.		
Fox, F. H. L.		
Fox, H. E.	Capt.	R.A.M.C., East Lancs. F.A.
Fox, Hugh W. ...	Capt.	R.A.M.C., Hospital Ship "Delta," M.E.F.
Fox, W. E.	Temp. Surg. ...	R.N., H.M.S. "Laurentic."
Fraser, E. Leslie ...	Private ...	"Artists'" Rifles.
Frazer, A.	Temp. Capt. ...	R.A.M.C.
Frazer, E. E.	Temp Capt. ...	R.A.M.C.
Frazer, F. M.	Temp. Capt. ...	R.A.M.C., X-ray Expert, Cairo Military Hosp.
Fremantle, F. E. ...	Lieut.-Col. ...	R.A.M.C. (T.F.).

French, Herbert ...	Temp. Major ...	R.A.M.C., Cons. Physician, Aldershot Command.
Fry, L. S.	Temp. Surg. ...	R.N., H.M.S. "Victory."
Fry, W. K.	Capt.	R.A.M.C., 1st Batt. Welsh Fusiliers. (Military Cross. Wounded.)
Fryer, Edwin	Temp. Lieut. ...	R.A.M.C.
Fulton, H.	Major	R.A.M.C. (T.F.), O.C. 12th (2nd London) F.A.
Gabell, A. H.	2nd Lieut. ...	340th Brigade R.F.A.
Gaffney, E. J.	Temp. Lieut. ...	R.A.M.C.
Galbraith, D. H. A. ...	Temp. Lieut. ...	R.A.M.C.
Galloway, W. D. ...	Lieut. and Temp. Surg.	H.M.S. "Cornwallis." (Commended for service in action, Gallipoli.)
Garrard, N.	Temp. Lieut. ...	R.A.M.C.
Gaskell, D. K.		
Gater, H. J.	Temp. Lieut. ...	R.A.M.C.
Gatley, C. A. R. ...	Temp. Lieut. ...	R.A.M.C.
Gavin, L. S. W. ...		Surg. to King George's Hosp, etc.
Genge-Andrews, G. E....	Temp Lieut. ...	R.A.M.C.
George, A. L.	Temp. Capt. ...	R.A.M.C.
German, J. B.	Temp. Capt. ...	R.A.M.C. (Late Surgeon R.N.)
Gibb, C. de W. ...	Capt.	R.A.M.C., 15th F.A.
Gibson, C. C. G. ...	Temp. Capt. ...	R.A.M.C.
Gibson, H. G.	Capt.	R.A.M.C.
Gilbert, T. H.		
Gilkes, M. D'O. ...		Hon. Surg. to Auxiliary Military Hosp., Ludlow.
Glaisby, K.		
Glanville, L. S. H. ...	Temp. Lieut. ...	R.A.M.C.
Glendinning, V. ...	Temp. Lieut. ...	R.A.M.C.
Glover, C.	Surg. Dentist...	H.M. Hosp. Ship "Plassy."
Glover, E. N.	Temp. Lieut. ...	R.A.M.C.
Goble, E. W.	Lieut.	R.A.M.C.
Goble, F. G.	Staff Surg. ...	R.N.
Godding, H. C. ...	Temp. Capt. ...	R.A.M.C. (Military Cross.)
Goldie, E. G.	Temp. Capt. ...	R.A.M.C.
Goldstein, H. M. ...	Capt.	R.A.M.C., 2nd N.Z.F.A.
Goodall, E.	Tp. Lieut.-Col..	R.A.M.C., Welsh Metn. War Hosp., Whitchurch, nr. Cardiff.
Goodall, E. W. ...		M.O. Hôpital Anglais, Nevers. (Queen Alexandra's Hosp., Dunkerque.)
Goodhart, S. W. ...	Capt.	R.A.M.C., St. Mark's (No. 2 General) Hosp.
Goodwin, E. S. ...		
Goss, J.	Temp. Lieut. ...	R.A.M.C.
Gough, Bernard B. ...	Lieut.	R.A.M.C., 8th South Staffs. (Killed in action in Belgium, February 17th, 1916.)
Gould, C. H.	Temp. Surg. ...	R.N., H.M.S. "Dartmouth."
Graham, L. A. J. ...	Temp. Capt. ...	R.A.M.C.
Granger, E.	Temp. Surg. ...	R.N.
Gray, A. C. H. ...	Major	R.A.M.C. (Mentioned in despatches.)
Gray, H. M.	Capt.	R.A.M.C. (Canadian A.M.C.)
Gray, St. G. B. D. ...	Surg. Prob. ...	R.N.V.R., H.M.S. "Staunch."
Green, Arthur	Lieut.	R.A.M.C., 2nd East Anglian F.A.
Greene, C. W.	Capt.	R.A.M.C. (Mentioned in despatches.)
Greenfield, D. G. ...	Temp. Lieut. ...	R.A.M.C.
Greenwood, A. A. ...	Lieut.	R.A.M.C., 37th General Hosp., Salonika.
Gregor, J. B.		
Greves, E. H.		Cons. Physician to Red Cross Hosp., Bournemouth.
Grice, J. W	Temp. Capt. ...	R.A.M.C.
Griffin, E. H.	Temp. Capt. ...	R.A.M.C., 12th Northumberland Fusiliers. (Twice mentioned in despatches. Military Cross.)
Griffin, T. H.	Temp. Lieut. ...	R.A.M.C. (Dental).
Griffiths, Chas. T. ...	Lieut.-Col. ...	R.A.M.C. (T.F.). (Territorial Decoration. Hon. Associate of Order of St. John of Jerusalem.)
Griffiths, H. L. S. ...	Temp. Capt. ...	R.A.M.C.
Grobbelaar, P. E. ...		
Groves, H. S.	Capt.	R.A.M.C.

Growse, W.		Senior Surg., V.A.D. Red Cross Hosp., Kenilworth.
Guinness, A. F. G. ...	Temp. Lieut. ...	R.A.M.C.
Gwatkin, A. J. ...	Temp. Lieut. ...	R.A.M.C. (Dental).
Gwyn-Davis, W. ...	Capt ...	..3rd Batt. The King's Regt.
Gwyn-Morris, O. ...		
Gwynn, W. P.	Lieut.-Col. ...	R.A.M.C.
Haine, C. F.	Temp. 2nd Lieut. ...	14th Royal Fusiliers.
Hall, A. W.	Colonel ...	A.M.C. (Mentioned in despatches.)
Hall, E. S.	Temp. Capt. ...	R.A.M.C. (Mesopotamia Ex. Force.)
Hall, R. W. B. ...	Staff Surg. ...	R.N.
Hallett, L. R. J. ...		
Ham, B. B.	Temp Capt. ...	R.A.M.C.
Hamilton, Geo. ...	Temp. Surg. ...	R.N. (Mentioned in despatches.)
Hammond, J. A. B. ...	Temp. Lieut. ...	R.A.M.C., 24th General Hosp., B.E.F.
Hancock, A. C ...	Temp. Capt. ...	R.A.M.C. (Mentioned in despatches.)
Hancock, E. D. ...	Temp. Major ...	R.A.M.C., Clandon Park Red Cross Hosp.
Harden, E.	Lieut.	R.A.M.C. (T.F.), Millbank Hosp.
Hardy, E.		
Hardy, G. F.	Temp. Capt. ...	R.A.M.C., Heavy Artillery Group, 23rd Brigade.
Hardy, H. M.	Temp. Lieut. ...	R.A.M.C., 27th General Hosp., Mudros and Cairo.
Hare, E. C.	Colonel ...	
Harkness, A. H. ...	Surg.	R.N.
Harland, G. B. ...	Capt.	I.M.S.
Harrington, F. J. ...		
Harris, H. O. W. ...		Dental Surg. to Red Cross Hosp., Hinton St. George.
Harris, L. Price ...	Capt.	R.A.M.C., 2/4th London F.A.
Harris, W. J.	Temp. Capt. ...	R.A.M.C.
Harrison, E. W. ...	Temp. Surg. ...	R.N., H.M.S. "Pembroke."
Harrison, Harold ...		Dental Surg. to Anglo-Russian Hosp., Petrograd.
Harrison, S. S. B. ...	Capt.	R.A.M.C. (T.F.), 1/3rd North Midland F.A.
Hart, E. R.	Temp. Lieut. ...	R.A.M.C.
Hart, J. A.		
Hartnell, E. B. ...	Temp. Capt. ...	R.A.M.C., London Mounted Brigade. (Died at Cairo, April 24th, 1916.)
Hartnell-Beavis, J. ...	Lieut.	R.A.M.C. (Private Hosp. work in Antwerp, Furnes and Serbia.)
Harvey, C. P.		T.C.M.P., 346th Co., N.T.A.S.C.
Harvey, J. H.		Civil M.P., 3rd Dorset Regt.
Hawkesworth, H. ...		M.O. in charge, Devon and Cornwall Territorials.
Haycraft, G. F. ...	Capt.	R.A.M.C. (T.F.), 1/3rd North Midland F.A., No. 4 Stationary Hosp.
Haynes, C. G.	2nd Lieut. ...	4th King's Royal Rifles.
Haynes, F.		Dental Surg., V.A.D. Hosp., Rugby, and Lilbourne Aerodrome.
Hayward, M. C. ...	Capt.	R.A.M.C. (T.F.), Home Counties F.A. (Wounded at Ypres. Died August 23rd, 1916.)
Hearnden, W. C. ...		On Staff, Auxiliary War Hosp., Leatherhead.
Heasman, H. W. ...	Temp. Lieut. ...	R.A.M.C.
Heatherley, F. ...	Temp. Lieut. ...	R.A.M.C.
Heaton, T. B.	Capt.	R.A.M.C. (S.R.).
Hedden, R.		M.O. to troops, Honiton.
Helsham, C. T.		
Henderson, W. ...	Temp. Capt. ...	R.A.M.C.
Hendren, E. S. ...	A.B.	R.N.V.R.
Henry, A. M.	Surg.	R.N., H.M.S. "President."
Henry, C. J.	[illegible]	H.A.C., "A" Battery, M.E.F.
Hewetson, H.	Lieut.-Col. ...	R.A.M.C.
Hibberd, C. E.	Temp. Capt. ...	R.A.M.C.
Hibbert, W. L. ...	Capt.	R.A.M.C. (T.F.), 47th C.C.S., France.
Hickes, Chas.	Private ...	A.S.C. (Motor Transport).
Hickman, G. H. ...	Temp. Lieut. ...	R.A.M.C. (Dental).
Higgens, Chas. ...		County of London War Hosp.
Hilliard, M. A. ...	Lieut.	R.A.M.C., 22 General Hosp.
Hills, W. E.	Lieut.	R.A.M.C.

Hillstead, H. T. ...		Civil M.O., Rough Riders.
Hind, W.	Major ...	... R.A.M.C.
Hilton, C. T.	Temp. Capt.	... R.A.M.C.
Hilton, G. J.	Capt. ...	... R.A.M.C., 30th Stationary Hosp., Salonika.
Hind, G. R.		Surgeon, Stoke-on-Trent War Hosp.
Hinde, E. B.	Capt. ...	... R.A.M.C. (T.F.), 2nd East Anglian F.A.
Hitchings, D. B. ...		
Hodgkinson, R. J. ...	2nd Lieut.	... Wounded.
Hodgson, F.	Capt. ...	... R.A.M. C., East Lancs. F.A.
Hodgson, H.		M.O., Hants Carbineers Yeomanry.
Hodgson, S.	Capt. ...	... R.A.M.C. (T.F.), 2/1st East Lancs. F.A.
Hodgson, V. J. ...		Surg. to Queen Mary's Naval Hosp., Southend-on-Sea.
Hodgson, W. A. ...		Civil Dent. Surg., 3/6th London R.F.A.
Hodson, J E	Temp. Lieut.	... R.A.M.C.
Hogarth, B. W. ...	Temp. Major	... R.A.M.C., M.O., 1st Div. Bomb School.
Hogben, H. F. T. ...	Lieut. ...	... Norfolk Regt., B.E.F. (Killed in action whilst serving in Mesopotamia, Nov. 23rd, 1915.)
Holborn, F. M. ...		Dent. Surg., Tooting Military Hosp.
Hole, K. H.	Surg. ...	... R.N., H.M.S. "Thames."
Hollands, W. G. ...	Lieut. ...	... 7th Batt. Royal Fusiliers.
Hollist, G. W. C. ...	Capt ...	... R.A.M.C. (T.F.), Home Counties F.A.
Hollom, F. M.		Civil Div. Surg., Tooting Military Hosp.
Holloway, G. W. ...	Surg. ...	... R.N., H.M.S. "Impregnable."
Holloway, S. F. ...	Temp. Lieut.	... R.A.M.C.
Holman, C. C.	Temp. Capt.	... R.A.M.C., 40th General Hosp., I.E.F.
Holman, R. C		Medical Examiner of Recruits, Midhurst District.
Holmes, Thos.	Capt. ...	... R.A.M.C., 5th Southern General Hosp.
Holmes, T. F.	Temp. Major	... R.A.M.C., Bagthorpe War Hosp.
Hopkins, F. G. ...	Temp. Lieut.	... R.A.M.C.
Hopkins, H. L. ...	Lieut. ...	... R.A.M.C. (Killed whilst serving in France, September, 1914.)
Hopson, M. F.		Hon. Cons. Dent. Surg. to War Hosps. in London Command.
Hopson, M. Fred ...	Surg. ...	... R.N., Zanzibar.
Hopson, M. G. S. ...	Lieut. ...	.. A.S.C. Horse Transport.
Horsley, L.	Capt. ...	... R.A.M.C., 13th General Hospital, Boulogne.
Horton, J. H.	Major ..	... I.M.S., 12th Indian Division. (D.S.O.)
Housden, C. H. ...		Hon. Dent. Surg. to Thorncombe Military Hosp.
Howard, C. R. ..	Lieut. ...	... R.A.M.C. (South African Medal, 5 bars.) (East African Expeditionary Force.)
Howard, J. A. ...		Radiographer, Croydon Military Hosp.
Howe, G. H.	Lieut. ...	... London Rifle Brigade.
Howell, J. N. O. ...		Cons. Surg., Cheltenham Red Cross Hosp.
Hughes, E. C.	Capt. ...	... R.A.M.C. (T.F.).
Hughes, E. P. L. ...	Surg. ...	... R.N., H.M.S. "Prince George."
Hughes, Sidney ...	Temp. Capt.	... R.A.M.C., 3rd Home Counties F.A.
Hull, A. J.	Major ...	... R.A.M.C. (Mentioned in despatches.)
Humphreys, F. R. ...	Capt ...	... R.A.M.C. (T.F.), O.C. 3/2nd London F.A.
Humphry, L.	Lieut. Col.	... R.A.M.C. (C.M.G., 1916.)
Hunot, F. G.	Surg. ...	... R.N.
Hunt, G. H.	Capt. ...	... R.A.M.C., London C.C.S. (Mentioned in despatches.)
Huntley, Edgar ...	Temp. Lieut.	... R.A.M.C., Military Hosp., Fovant, Hants.
Hurst, A. F.	Major ...	... R.A.M.C., Medical Advisory Committee, Mediterranean E.F.
Husbands, F. A. ...		Dental Surg. to V.A.D. Hosp., Northampton.
Hutchinson	Capt. ...	... 8th Field Amb., A.I.F.
Hylton, D. Y.		Dent. Surg., Bath War Hosp.
Infield, S.	Temp. Lieut.	... R.A.M.C.
Ingram, P. C. P. ...	Capt. ...	R.A.M.C. (T.F.), 3rd Welsh F.A.
Instone, N.	Temp. Capt.	... R.A.M.C.
Iredell, A. W.	Staff Surg.	... H.M.S. "Proserpine."
Irvine, L. C. Dundas ...	Surg. ...	... R.N.V.R., Hospital Ship "Plassy."
Jackson, F. D. S. ...	Capt. ...	... R.A.M.C. (T.F.), London (City of London) General Hosp.
Jackson, R. W. P. ...	Temp. Lieut.	... R.A.M.C., 91st F.A.

Jacob, E. D.	Temp. Major	R.G.A. (T.F.).
Jalland, M. T.		Hon. Cons. Surg. to Military Hosp., York.
James, B. E.	Lance-Corpl.	23rd Fusiliers (Sportsmen).
James, J. S. H.	Lieut.	Killed in action.
James, W. Culver	Surg.-Col.	H.A.C., Queen Alexandra Military Hosp.
Jarvie, J. M.	Temp. Lieut.	R.A.M.C.
Jephcott, C.	Lieut.	R.A.M.C. (T.F.).
Jepson, A. C.	Temp. Capt.	R.A.M.C.
Jerwood, B. E.	Lieut.	
Jessop, P. E.	Temp. Capt.	2/5th Batt. Loyal North Lancs.
John, D. W.	Capt.	R.A.M.C. (S.R.), 8th North Stafford Regt.
Johnson, A. T. L.	Temp. Lieut.	R.A.M.C. (Dental Surg.)
Johnson, E. E.	Lieut.	R.A.M.C. (Dental).
Johnston, W. R		In charge Ambulance arrangements for Air Raids, Hull.
Jonas, J. H.	Capt.	R.A.M.C.
Jones, B.	Temp. Capt.	R.A.M.C.
Jones, C. E. M.	Capt.	R.A.M.C. (T.F.), Indian Ex. Force. (Prisoner of War at Kut.)
Jones, C. Price	Temp. Lieut.	R.A.M.C.
Jones, D. W.	Temp. Capt.	R.A.M.C.
Jones, E. Shelton	Temp. Capt.	R.A.M.C., 11th Royal Welsh Fusiliers.
Jones, G. B. H.	Capt.	R.A.M.C., 4th Hants.
Jones, G. M.	Temp. Capt.	R.A.M.C., Member of War Office Travelling Medical Board.
Jones, Hugh E.		Hon. Cons. Surg. to Military Hosps., Liverpool, for Diseases of Ear, Nose, and Throat.
Jones, H. W.	Tp. Hon. Lieut.	R.A.M.C.
Jones, J. Gayner		
Jones, J. H.	Temp. Capt.	R.A.M.C.
Jones, M. Parry	Fleet Surg.	R.N., H.M.S. "Exmouth."
Jones, R. O. H.	Temp. Capt.	R.A.M.C.
Jones, R. T.	Capt.	R.A.M.C. (T.F.), Western General Hosp.
Jones, R. W.		Dental Surg. to Mile End Military Hosp.
Jones, Sidney	Temp. Lieut.	R.A.M.C.
Jones, T. Lewis	Temp. Capt.	R.A.M.C., Welsh Hospital in the East.
Jones, W. H. T.	Temp. Lieut.	R.A.M.C., Indian Service.
Joslem, H.	Capt.	R.A.M.C., Canadian A.M.C.
Joynt, H. F.	Capt.	R.A.M.C.
Kearney, S. J.	Lieut.	R.A.M.C. (T.F.), North Midland C.C.S.
Keer, J. C.		M.O. to Rendlesham Park Camp.
Keer, K. J. T.	Temp. Capt.	1/6th Suffolk Regt.
Kelsey, W.	Lieut.	Military Cross. (Wounded.)
Kemp, J. Wallace	Major	R.A.M.C. (T.F.), 1st London C.C.S.
Kendall, N. E.	Lieut.	R.A.M.C., 245 M.T.C., A.S.C., Salonika Forces.
Kennedy, R. S.	Lieut.	R.A.M.C.
Kennealy, W. J.	Trooper	Van Deventers Horse, South African Forces.
Ker, W. P.	Temp. Lieut.	R.A.M.C.
Key, M. Aston		M.O. with R.A.M.C., in charge Reception Hosp., Portsmouth.
Kield, W. S. T.	Temp. Lieut.	R.A.M.C.
Kidman, G. E.	Lieut.	R.A.M.C. (T.F.).
King, Geoffrey	Surg.	R.N.
King, L. A. B.	Temp. Capt.	R.A.M.C. (D.), Dental Surg. to Jaw Wounds Hosp., Aldershot.
King, P.	2nd Lieut.	
King, R. Manton	Temp. Capt.	R.A.M.C., Army Dental Surgeon, Alexandria, Egypt.
Kinsey, Morgan A.	2nd Lieut.	R.A.M.C.
Kirkland, G. B.		
Kirkman, A. H. B.	Temp. Lieut.	R.A.M.C., No. 11 General Hosp., France.
Knaggs, F. H.		M.O. Huddersfield War Hosp.
Knaggs, R. L.	Major	R.A.M.C., 2nd Northern General Hosp., Leeds.
Knight, H. S.	Temp. Lieut.	R.A.M.C.
Knight, R. V.	2nd Lieut.	8th Batt. City of London Regt.
Knowles, G. F.		Dentist to four Red Cross Hosps.
Kyle, J.	2nd Lieut.	"Artists'" Rifles.
Kynaston, A. E. F.	Surg.	R.N., H.M.S. "Devonshire." (Died.)
Kynaston, A. E. F.	Lieut.	R.N., H.M.S. "Devonshire." (Killed.)

Laborda, F. E. R.	Temp. Capt.	R.A.M.C.
Lacey, G. E. W.	Temp. Surg.	R.N.
Lacey, T. W.	Temp. Major	R.A.M.C., in charge of Royal Military Academy, Woolwich.
Lacey, Wm. S.	Temp. Lieut.	R.A.M.C., 140th F.A.
Lancaster, H. F.	Capt.	R.A.M.C. (T.F.), 2nd London General Hosp.
Landon, E. E. B.	Capt.	R.A.M.C. (T.F.).
Lane, Sir W. A., Bt.	Temp. Lieut.-Col.	R.A.M.C.
Langdon, W. M.	Capt.	R.A.M.C. (T.F.), London F.A.
Langston, W. M.	Capt.	R.A.M.C. (T.F.), 3/4th London F.A.
Lansdale, W. M.	Capt.	R.A.M.C. (S.R.).
Lansdown, R. G. P.	Major	R.A.M.C. (T.F.), 2nd Southern General Hosp.
Lauder, J. L.	Temp Capt.	R.A.M.C. (D.S.O.) (Was at Wittenburg.)
Laver, B. L.	2nd Lieut.	R.F.A.
Laver, C. H.	1st Lieut.	R.F.A.
Lavers, Norman		Physician to Bath War Hosp.
Lawson, F. W.	Temp. Surg.	R.N.
Lawson, G. L. L.	Tp. Lieut.-Col.	R.A.M.C.
Lawson, S.	Tp. 2nd Lieut.	R.A.M.C. (Dental), 10th Leicestershire Regt.
Layton, T. B.	Temp. Major	R.A.M.C., 2/4th London F.A.
Leckie, Malcolm	Capt.	D.S.O. (Died of wounds at Frameries, August 28th, 1914.)
Lee, F. W.	Temp. Lieut.	R.A.M.C., Canadian A.M.C.
Lee, Harry	Capt.	R.A.M.C. (T.F.), 1st West Riding F.A., 49th West Riding Divn.
Leeming, A.	Temp. Lieut.	R.A.M.C.
Leeming, H. N.	Temp. Lieut.	R.A.M.C., 10th C.C.S.
Leigh, H. V.	Temp. Capt.	R.A.M.C., 31st General Hospital, Egypt.
Le Sage, C. F.		Resident M.O., Norfolk War Hospital.
Leviseur, E. A.		
Leviseur, H. J.		
Levy, A. G.	Lieut.	R.A.M.C.
Lewin, G.	Temp. Lieut.	R.A.M.C.
Lewis, Cyril G	Temp. Capt.	R.A.M.C., No. 10 F.A., B.E.F.
Lewis, K. Day	Lieut.	R.A.M.C., 9th West Yorks Regt., 11th Division.
Lewis, R. P.	Major	R.A.M.C. (Mentioned in despatches.)
Liebson, A. S.	Capt.	R.A.M.C., M.O., 3rd South African Infantry.
Lindsay, G. P.	Lieut.	2nd Border Regt. (Twice wounded.)
Litchfield, P. C.	Lieut.	15th Motor Ambulance Company, 3rd Army.
Littlejohns, A. S.	Major	R.A.M.C.
Llarena, E. F.	2nd Lieut.	Machine Gun Officer, 2nd Suffolks Regt. (Killed at Ypres.)
Lloyd, F. G.	Temp. Surg.	R.N., attached R.M.A. Anti-Aircraft Brigade.
Lloyd, V. E.	Lieut.	R.A.M.C., R.E. Mess, Longmoor Camp.
Lockyer, G. E.	Temp. Capt.	R.A.M.C.
Logan, F. T. B.		Hon. Surg. Foye House Red Cross Hosp. (Died.)
Long, G. B. S.	Temp. Surg.	R.N.
Longhurst, S. H.	Temp. Lieut.	R.A.M.C., Inspecting Dental Officer, Western Command.
Loud, Frank	Major	R.A.M.C., Sussex R.G.A.
Loveday, W D.		M.O. in charge, Red Cross Hosp., Wantage.
Loveluck, C. A.		
Lowe, E. Cronin		M.O. in charge Southport Cottage Auxiliary Military Hosp. and Moels Hall Auxiliary Hosp.
Lowe, F. A.	Lieut.	R.N.V.R., "Collingwood" Batt (Killed in action at Gallipoli, June 4th, 1915.)
Lower, N. Y.		M.O., V.A.D. Hosp., Corton, Radnorshire.
Lucas, C. R.	Hon. Lieut.	R.A.M.C.
Lucas, T. C.	Major	R.A.M.C., 62nd Division.
Luce, R. H.	Colonel	T.F. Reserve. (C.B., 1916.)
Lucey, H. C.	Temp. Capt.	R.A.M.C.
Lund, H.	Capt.	R.A.M.C. (T.F.), 2nd Western General Hosp.
Lynn, Ed.		Medical Officer at Auxiliary Hosp., Woolwich.
Lyon, H. J.		
McAlpin, K. F.		
McDermott, B.	Temp. Lieut.	R.A.M.C.
McDougall, J. T. M.	Temp. Capt.	R.A.M.C., 29th Stationary Hosp., Salonika.

McGregor, G.		Alexandra Military Hospital, Cosham.
Mackenzie, M.		
McManus, D.	Capt. ...	... R.A.M.C., "Inns of Court" O.T.C.
McNair, A. J.	Lieut. ...	... R.A.M.C.
Maggs, W. A.		Dental Surg. to King George's Hospital.
Magrath, C. W. S. ...	Lieut.-Col.	... R.A.M.C. (President, Standing Medical Board, Portsmouth.)
Male, H. C.		Croydon War Hosp.
Mandel, L.	Surg. ...	... R.N., H.M.S. "Vivid."
Manfield, G. H. H. ...	Capt. ...	... R.A.M.C., 2nd North Midland F.A. (Military Cross.)
Mann, H. C. Corry ...	Surg. ...	... R.N., H.M.S. "Duncan."
Manning, T. D. ...		Civil Surg., 3rd Wilts. Hosp.
Manser, F. B.	Temp. Lieut.	... R.A.M.C., 43rd C.C.S.
Marsh, A. P.		Civil Dentist to troops at Seaford, Rye, and Lydd.
Marriott, H. B. ...	Fleet Surg.	... R.N.
Marsh, H. R.	Temp. Lieut.	... R.A.M.C.
Marshall, B. G. ...	2nd Lieut.	... 3rd Northants Regt.
Marshall, E. S. ...	Temp. Capt.	... R.A.M.C. (Mentioned in despatches.)
Marshall, Geoffrey ...	Capt. ...	... R.A.M.C. (S.R.).
Marshall, R. P. ...	Temp. Lieut.	... R.A.M.C., 35th Heavy Artillery Group.
Marshall, W. L. ...	Lieut.-Col.	... R.A.M.C., Huddersfield War Hospital.
Martin, J. N.	2nd Lieut.	... A.S.C. (Wounded.)
Mash, O. N.		
Mason, J. B.	Temp. Capt.	... R.A.M.C.
Masters, J. A.	Lieut.-Col.	... R.A.M.C. (T.F.).
Mather, H.	Temp. Lieut.	... R.A.M.C.
Matson, R. C.	Temp. Capt.	... R.A.M.C.
Matthews, G.	Temp. Lieut.	... R.A.M.C.
Matthews, T.	Temp. Lieut.	... R.A.M.C.
Maxted, G.		Ophth. Surg. to Norfolk War Hosp.
Maxwell, E. J.	Temp. Lieut.	... R.A.M.C., 29th General Hosp., Salonika.
Maxwell, J. E.		
May, P. M.	Fleet Surg.	... R.N., H.M.S. "Empress of India."
May, R. E. G.		Hon. M.O., Fairlawn Military Hosp., Honor Oak.
Maybury, A. V. ...	Capt ...	... R.A.M.C. (T.F.), 26th F.A., B.E.F.
Mayer, R. G.		
Maynard	Lieut.-Col.	... R.A.M.C, No. 22 General Hospital.
Meade-King, W. T. P.	Temp. Major	... R.A.M.C., Wessex F.A.
Medlock, C. H.	Corporal	... "Artists'" Rifles, Despatch Rider.
Messenger, H. L. ...	Temp. Lieut.	... R.A.M.C.
Messent, R. J.	Temp. Capt.	... Sussex R.G.A. (T.F.).
Metcalfe, B. B. ...	Temp. Capt.	... R.A.M.C.
Mew, G. M.	2nd Lieut.	...
Meyrick-Jones, H. ...	Temp Capt.	... R.A.M.C., B.E.F.
Michell, R.	Capt. ...	... R.A.M.C. (T.F.).
Miller, A. A.	Temp. Lieut.	... R.A.M.C., 24th C.C.S.
Miller, F. C.		
Miller, G. S.	Temp. Capt.	... R.A.M.C., No. 1 F.A. (Killed in action.)
Millett, H.	Lieut. ...	... Royal Marines (R.N.D.). (Mentioned in despatches, Dardanelles, September, 1915.)
Milligan, R. A. ...	Major ...	... R.A.M.C. (T.F.).
Mills, C. H.	Temp. Capt.	... R.A.M.C.
Mills, T. I.	Capt. ...	... R.A.M.C. (T.F.), 2/1st West Riding F.A.
Milne, J. B.		M.O., Brook War Hosp.
Milner, A. E.	Major ...	... R.A.M.C.
Milton, E. F.	Temp. Lieut.	... R.A.M.C., 89th F.A.
Milton, Leonard ...	Capt. ...	... R.A.M.C.
Milton, W. T. ...	Temp. Lieut.	... R.A.M.C.
Minett, E. P.	Capt. ...	... R.A.M.C. (T.F.), 2/4th London F.A.
Minett, P. O.	Staff Surg.	... R.N.
Minns, A. G.		Civil Practitioner in charge of Troops, 69th (E.A.) Divn.
Minns, A. H.	Capt. ...	... R.A.M.C., 39th F.A. (Twice mentioned in despatches. Military Cross.)
Minns, H. N.	Temp. Capt.	... R.A.M.C., 13th F.A., 69th Divn. (Military Cross.)

Minns, W. Noel	Capt.	R.A.M.C. (Military Cross for service in Gallipoli.)
Mitchell, D. A.	Surg.	R.N., Royal Naval Hosp., Malta.
Mitchell, H. E. H.	Temp. Lieut.	R.A.M.C.
Moffatt, H. A.	Lieut.-Col.	S.A.M.C. (Surgical Specialist.)
Monaghan, P. J	Capt.	South African M.C.
Monk, G. B.	2nd Lieut.	2nd Batt. Royal Warwicks. (Killed in action, December 14th, 1914.)
Montgomery, R.	Capt.	R.A.M.C. (S.R.). (Mentioned in despatches.)
Moore, A. G. H.	Temp. Lieut.	R.A.M.C.
Moore, J. Y.	Capt.	R.A.M.C. (S.R.). (Mentioned in despatches, Gallipoli.)
Moore, Lionel W.	Lieut. (acting Capt.)	Gloucester Regt. (Killed in action, August 29th, 1916.)
Moore, P. W.	Temp. Capt.	R.A.M.C. (Standing Medical Board, Caxton Hall.)
Moore, R. A.		
Morgan, E. C. de M.	Temp. Surg.	R.N., H.M.S. "Victory."
Morgan, M. J.		M.O., Aberystwith Red Cross Hosp.
Morgan, O. G.	Hon. Lieut.	R.A.M.C.
Morgan, W.	Lieut.	R.A.M.C. (T.F.), Welsh Border M. Brigade F.A.
Morley, T. S.		Admiralty Surgeon.
Morrell, F. H.	Temp. Lieut.	R.A.M.C. (D.).
Morres, F.	Temp. Lieut.	R.A.M.C.
Morris, Arnold	Capt.	R.A.M.C. (T.F.), Royal Warwickshire Regt.
Morris, H. W. G.		Civilian Dentist to R.E. Camp, Houghton Regis.
Morrish, D. B.	2nd Lieut.	K.O.Y.L.I (Killed in action in France.)
Morrison, J. H. L.	Lieut.-Col.	R.A.M.C. (T.F.).
Morrison, J. T. J.	Major	R.A.M.C., 1st Southern Gen. Hosp.
Mossop, C. H.	Temp. Lieut.	R.A.M.C., Ambulance Train, France.
Mothersole, R. D.	Temp. Lieut.	R.A.M.C., 25th General Hosp. and 31st C.C.S.
Mottram, G. N.	Temp. Lieut.	R.A.M.C.
Mottram, M.	Temp. Capt.	R.A.M.C.
Mugford, J. L.		
Muir-Smith, H.		
Muir-Smith, L.	Lieut.	R.A.M.C., 25th C.C.S., Salonika.
Mullally, G. T.	Temp. Capt.	R.A.M.C. (Surgical Specialist.)
Mullins, H. R.	Temp. Capt.	R.A.M.C., South African M.C.
Mumford, W. G.	Temp. Capt.	R.A.M.C. (Surgical Specialist.) (Mentioned in despatches.)
Munday, R. B.	Prob. Flight-Sub. Lieut.	
Munden, W. P. H.	Temp. Capt.	R.A.M.C., 16th Sherwood Foresters.
Munro, D. J.		R.N.
Munro, H.	Temp. Capt.	R.A.M.C.
Murray, H. S.	Temp. Surg.	
Murray, R. W.	Major	R.A.M.C., Resdt. Surg., Fazakerley Hosp.
Musgrove, E. H.	Capt.	Brecons. Batt., South Wales Borderers.
Myott, E. C.	Temp. Capt.	R.A.M.C.
Nash, L. G.	Lieut.	R.A.M.C.
Neal, F. D.		
Neely, Guy	Lieut.	R.A.M.C., 143rd F.A.
Neely, Hugh B.	2nd Lieut.	3rd Batt. Suffolk Regt. (Killed in action, Ypres, April 25th, 1915.)
Neely, W. G. S.	Temp. Lieut.	R.A.M.C.
Nelson, K. M.	Capt	R.A.M.C. (S.R.).
Newland-Pedley, F.		Dent. Surg., No. 2 Red Cross Hosp., Rouen.
Newman, F. C.	Temp. Surg.	R.N., H.M.S. "Commonwealth."
Nicholls, F. J.		Anæsthetist, Kempston Red Cross Hosp.
Nichols, W. H.	Capt.	R.A.M.C. (Accidentally killed in India, February 22nd, 1916.)
Nicholson, C. R.	Temp. Major	R.A.M.C., O.C. St. Ignatius Hosp., Malta. (Order of St. Sabe, 5th class, by King of Serbia.)
Nicholson, J. W.	Major	R.A.M.C., No. 1 General Hosp.
Nicol, Burton	Temp. Major	South African M.C.
Ninnis, R. P.	Temp. Surg.	R.N., H.M.S. "Neptune." (Esquire of the Order of St. John of Jerusalem.)
Norburn, A. E.		Surgeon, Bath War Hosp.

Norman, Albert		Honorary Staff of King George's Hosp.
Norman, T.	Surg.	R.N., H.M.S. "Comus."
Nunn, G.	Staff Surg.	R.N. (Wounded.)
Oates, J. L.		
O'Callaghan, T. T.	Temp. Lieut.	R.A.M.C., Karachi, India.
Odgers, N. Blake	Temp. Major	R.A.M.C.
Ogilvie, W. H.		Surg. to Urgency Cases Hosp., 3rd French Army, Argonne.
Oliver, C. H.	Temp. Lieut.	Machine Gun Officer, 14th York and Lancaster.
Oliver, Norman	Temp. Capt.	R.A.M.C., in charge, No. 4 Hosp. for Officers, Ham Common.
Ollis, M. S.		Civil Dental Surg., Training Service, H.M.S. "Impregnable."
Orchard, H. P.	Capt.	T.F.
Ordish, F. J.		
Ormond, A. W.	Capt.	R.A.M.C., in charge, Ophth. Dept., 2nd London General Hosp.
Ormond, Sidney J.	Capt.	R.A.M.C. (Working in hospital at Ramleh, Alexandria.)
Osborn, A. G.	Temp. Capt.	R.A.M.C., 2/4th Queen's Royal West Surrey Regt.
Osborn, F. A.	Temp. Capt.	R.A.M.C.
Osburn, A. C.	Tp. Lieut.-Col.	R.A.M.C., O.C., F.A. (Mentioned in despatches. D.S.O.)
Owen, J. H.	Capt.	R.A.M.C. (S.R.). (Wounded, Ypres, 1914.)
Owen, J. M.		Civil Surg., Admiralty, Fishguard.
Owsley, G. C.		Visiting Anæsthetist, Brook War Hosp.
Ozanne, R. C.	Major	R.A.M.C., 22nd C.C.S. (Mentioned in despatches.)
Packer, H. D.	Lieut.-Col.	R.A.M.C.
Paget, Peter	Major	R.A.M.C. (T.F.). (In India.)
Pakes, A. E. H.	Temp. Capt.	S.A. Union Defence Force.
Pakes, Walter C. C.	Capt. and Adj.	S.A.M.C., 4th F.A. (German East Africa.)
Pallant, H. A.	Temp Capt.	R.A.M.C., 1st Loyal North Lancs. (Wounded. Military Cross.)
Pallant, S. L.	Major	R.A.M.C. (Mentioned in despatches.)
Palmer, A. H.	Surg. Capt.	Staffs. Yeomanry.
Palmer, A. S. Morton		Commandant, Red Cross and St. Mary's Hosp., Worthing.
Palmer, Basil H.	Lieut.	11th Batt. Royal Lancaster Regt.
Palmer, H. J.		
Palmer, H. T.	Temp. Capt.	West African Medical Staff. (With Cameroons Ex. Force.)
Palmer, J. S.	2nd Lieut	2nd Batt. Durham Light Infantry.
Pantin, C. S.	Temp. Lieut	R.A.M.C.
Parker, W. Gibson	Temp. Lieut.	R.A.M.C. (In Egypt.)
Parkes, H. P.	2nd Lieut.	
Parmiter, B. R.	Temp. Capt	R.A.M.C., 6th Royal Irish Fusiliers.
Parry, Jas. Hales	Lieut.	I.M.S. Hosp. Ship "Glengorm Castle." (Alexandria.)
Parry, L. A.	Temp. Capt.	R.A.M.C.
Parry, R.		M.O. in charge, Eryri Auxiliary Hosp., Carnarvon.
Parry-Jones, O.	Capt.	R.A.M.C. (S.R.).
Price-Parry, H.		
Parsons, J. E. H.		M.O., 261 Co., R.D.C.
Partridge, Wm. L.	Temp. Lieut.	R.A.M.C., 14th Gloucester Regt.
Passey, R. D.	Temp. Lieut.	R.A.M.C.
Paul, F. T.	Major	R.A.M.C.
Paul, F. W.		Dental Surg., H.M. Hosp. Ship "Garth Castle."
Payne, J. Lewin		Hon. Cons. Dental Surg. to London Military Hosps.
Payne, O. V.		M.O., Alton Auxiliary Red Cross Hosp.
Peall, G Harcourt	Capt.	East African Medical Service.
Peall, P. A.	Temp. Major	R.A.M.C., County of London War Hospital.
Pearce, Dudley George	Capt.	East Kent (Buffs). (Killed, September 3rd, 1916.)
Pearson, G. B.	Capt.	R.A.M.C., Royal Bucks Hussars. (Wounded at Gallipoli.)
Peatfield, S. J.	2nd Lieut.	Berkshire Regt. (Died of wounds, July 16th, 1916.)
Pedley, C. F.	Surg.	Belgian Field Hospital.
Pedrick, P. V. G.	Temp. Lieut.	R.A.M.C.
Penfold, W. D.		
Perceval, J. L.	Capt.	R.A.M.C. (S.R.), No. 7 General Hospital, B.E.F.
Percival, H. F.	Temp. Surg.	R.N., H.M.S. "Tiger."
Peregrine, H. L.	Temp. Surg.	R.N., H.M. Hospital Ship "China."
Perkins, D. S.	Temp. Lieut.	R.A.M.C., H.M. Hospital Ship "Goorkha."
Perkins, H. E	Surg.	R.N., H.M.S. "Pembroke."

Pern, L.	Temp. Lieut.	R.A.M.C.
Pern, Montagu	Lieut.	R.A.M.C. (Killed in action, May 9th, 1915.)
Peters, E. A.	Temp. Capt.	R.A.M.C.
Pettey, C. E.	Capt.	R.A.M.C. (T.F.), 2/4th London F.A.
Phillipps, W. A.	Capt.	R.A.M.C.
Phillips, E.	Capt.	R.A.M.C. (Mentioned in despatches.)
Phillips, G. R.	Temp. Lieut.	R.A.M.C.
Phillips, R. E. G.	Capt.	R.A.M.C.
Phillips, W J.	Lieut.	R.A.M.C.
Pickett, L. R.	Temp Lieut	17th King's Royal Rifle Corps.
Picton-Phillips, W. E.	Capt.	R.A.M.C.
Pierce, C. E.	Temp. Capt.	R.A.M.C.
Pigeon, H. W.	Temp. Capt.	R.A.M.C.
Pike, D. R.	Temp. Lieut.	R.A.M.C.
Pilbeam, E. L.	Temp. Lieut.	R.A.M.C. (Dental), B.E.F.
Pilbeam, L. S.		B. Res. Brigade, Royal Horse Artillery.
Pilcher, E. M.	Lieut.-Col.	R.A.M.C. (D.S.O.)
Pillow, H. M. S.		
Pitt, G. N.	Major	R.A.M.C. (T.F.), 2nd London Gen. Hosp., King George's Hosp.
Platt, D. H.	Capt.	R.A.M.C. (T.F), County of London F.A.
Platt, Harry	Capt.	R.A.M.C., 2nd Western General Hosp.
Plumley, A. G. G.	Temp. Capt.	R.A.M.C., Med. Ex. Force.
Plummer, W. E.	Lieut.	R.A.M.C.
Pollard, C. A.		
Pollard, G. S.	Tp. Lieut.-Col.	R.A.M.C., Military Hosp., Taunton. (V.D.)
Pollock, C. E.	Colonel	R.A.M.C.
Pollock, R. G.		M.O., Warlingham Camp.
Pomeroy, J. M.	Temp. Lieut.	R.A.M.C.
Ponder, Constant W.	Capt.	R.A.M.C.
Ponder, R. R. B.		Civilian Dentist.
Poock, Graham		Civilian Dental Surg., Royal Naval Divn.
Portway, R. L.	Temp. Lieut.	R.A.M.C.
Powell, J. E.	Tp. Lieut.-Col.	R.A.M.C., in charge, F.A.
Powel-Smith. C.	2nd Lieut.	Durham Light Infantry.
Poyser, R. C.	Temp. Capt.	R.A.M.C.
Prall, S. E.	Colonel	I.M.S., Hospital Ship "Glengarn Castle."
Prentice, J.		M.O., No. 70 Kent. V.A.D. Hosp.
Prentis, J. E.	Temp. Lieut.	R.A.M.C., Alexandria.
Pretorius, W. J.		
Price	Lieut.	K.R.R.
Price, C. E.	Temp. Capt.	R.A.M.C.
Price, E. Seymour	Capt.	R.A.M.C., O.C. 3/6th London F.A.
Price, H. P.	Temp. Surg.	R.N., North Sea, Gallipoli, and Atlantic Patrol.
Price, J. A. P.	Major	R.A.M.C. (T.F.), in charge, Surg. Section, Reading War Hosp.
Price, P. S.	Temp. Capt.	R.A.M.C., 5th London F.A.
Prideaux, A. E. D.		Dorset Volunteer Regt. Transport Dept.
Pritchard, G. B.	Capt.	R.A.M.C. (T.F.), 2/4th London F.A.
Pryn, R. H. C.	Lieut.	R.A.M.C. (S.R.).
Pryn, Wm. R.	Lieut.	R.A.M.C. (Died in Belgium, June 27th, 1915.)
Pryn, W. W.	Dep. Insp.-Gen.	R.N., Royal Naval Hosp., Gibraltar.
Pryor, W. R.	Lieut.	R.A.M.C. (Died on Service in France.)
Pugh, H. S.	Temp. Lieut.	R.A.M.C. (Dental).
Purdom, H. N.		Civil Dental Surg. to Troops and Red Cross Hosp., Clevedon.
Pye-Smith, C. D.	Temp. Capt.	R.A.M.C., 69th F.A.
Rahman, M. A.	Capt.	I.M.S.
Rand, T. A.	Lieut	2nd Wessex R.F.A.
Randall, C. N.	Temp. Lieut.	R.A.M.C.
Randell, R. M. H.		M.O., V.A.D. Kent, 41 and 96.
Rankine, R. A.	Surg.	R.N., H.M.S. "Pembroke."
Ransford, L. U.	Capt.	R.A.M.C. (T.F.), Essex Regt.
Ransford, J. E.	Capt.	R.A.M.C. (T.F.), 2/7th Lancs. Fusiliers.
Ransford, W. R.	2nd Lieut.	2/10th Gurkha Rifles.
Rawnsley, G. T.	Colonel	A.M.S. (C.M.G., 1916.)
Rayner, A. E.	Capt.	R.A.M.C. (T.F.), 2nd London Sanitary Co.

Raywood, J. R. I.	Colonel	A.M.S., A.D.M.S.S., Midland Divn., 48th Divn. T.F.
Reader, N. L. M.	Capt.	R.A.M.C.
Reader, S.	Temp. Lieut.	R.A.M.C.
Rees, G. H.	Major	R.A.M.C.
Rees, M. J.	Temp. Capt.	R.A.M.C.
Reeves, Albert	Temp. Lieut.	R.A.M.C., M.T. Reserve Depot, A.S.C., Grove Park, S.E.
Reid, A.	Lieut.	R.A.M.C. (T.F.), 1st City of London Sanitary Co.
Reid, Edgar	Major	R.A.M.C., 3rd Western General Hosp., Cardiff.
Reinhold, C. H.	Capt.	I.M.S., 111th Indian F.A. (Mentioned in despatches.)
Remington, W.		
Reynell, W. R.	Capt.	Australian Hosp., Boulogne.
Reynolds, A. J.		Dental Surg. to Troops, Yarmouth.
Reynolds, L. G.	Temp. Lieut.	R.A.M.C.
Reynolds, L. L. C.	Lieut.-Col.	O.C. 1st Bucks Batt. Oxford and Bucks Light Infy. (Wounded.)
Reynolds, Russell J.		Radiologist to Tooting Military Hosp. and Streatham War Hosp.
Reynolds, W. L. E.	Capt.	R.A.M.C. (S.R.), 56th F.A.
Reynolds, W.	Capt.	R.A.M.C., Canadian A.M.C.
Rice, H. G.	Capt.	R.A.M.C., Salonika.
Richards, C. H.		
Richards, D. O.	Tp. Hon. Capt.	R.A.M.C.
Richards, Ernest H.	Cadet	XI. Officer Cadet Batt.
Richards, J. F. G.	Lieut.	15th F.A., 5th Divn., 2nd Army.
Richards, J. G.	2nd Lieut	66th East Lancs. Divnl. Cyclist Co. (T.F.).
Richards, L. P.	Temp Lieut	R.A.M.C.
Richards, N. L.	Fleet Surg	R.N. (retd.) (Transport of Wounded.)
Richards, Owen	Temp. Capt	R.A.M.C. (Mentioned in despatches. D.S.O.)
Richardson, H.	Lieut.-Col.	R.A.M.C. (T.F.), Mounted Brigade F.A. (Mentioned in despatches.)
Richardson, W. S.	Capt.	R.A.M.C. (T.F.), 46 (1/1st Wessex) Casualty Clearing Station.
Riches, L. V. H.	Temp. Lieut.	R.A.M.C. (Dental).
Rigby, J. A.	Temp. Major	R.A.M.C.
Ring, C. A. E.	Temp. Capt.	R.A.M.C., Salonika.
Risdon, T. O.		
Rivers, A. T.	Surg.	R.N.
Roberts, Astley C.	Colonel	O.C. 2nd Home Counties Brigade R.F.A., India.
Roberts, C. S. Lane	Temp. Capt.	R.A.M.C., B.E.F. (Mentioned in despatches.)
Roberts, D. W. O.	Lieut	R.A.M.C.
Roberts, H. Jones	Lieut.-Col.	R.A.M.C.
Roberts, H. W.	Surg. Colonel	National Reserve. (V.D.)
Roberts, R. J.		M.O. in charge, Auxiliary Hosp. and Troops, Ventnor District.
Roberts, T. E.	Temp. Capt.	R.A.M.C. (Wounded.)
Roberts, T. H. F.	Temp. Capt.	R.A.M.C.
Roberts, W. O.	Temp. Lieut.	R.A.M.C.
Robertson, E. Guy	Temp. Capt.	R.A.M.C., No. 5 C.C.S., B.E.F.
Robertson, J. C.	2nd Lieut.	Cameron Highlanders. (Missing, believed killed.)
Robinson, F. C.	Staff Surg.	R.N., H.M.S. "Vivid."
Robinson, J. F.	Temp. Capt.	R.A.M.C., 2/2nd South Midland F.A.
Robinson, J. H.	Major	R.A.M.C., Dep.-Asst. Director of Medical Services, 2nd Rawal Pindi Divn.
Robinson, W.	Temp. Capt.	R.A.M.C.
Robinson, W. H.	Temp. Lieut.	R.A.M.C.
Robinson, W. Beresford		2nd London General Hosp.
Robinson, W. E.		Anæsthetist, King George's Hosp.
Robson, W. M.	Temp. Major	R.A.M.C.
Roche, E. H.		
Rodgers, N. P.		Hon. Dental Surg. to Auxiliary Military Hosp., Southall.
Rogers, F. E. W.	Lieut.	R.A.M.C. (T.F.), London (C. of London) Sanitary Co.
Rook, A. F.	Temp. Capt.	R.A.M.C.
Rook, H. C.	Capt.	R.A.M.C. (S.R.).
Rooke, E. M.	Temp. Lieut.	R.A.M.C.
Roome, A. M.	Temp. Capt.	R.A.M.C., 1/7th H.L.I.
Rose, Percy	Temp. Lieut.	R.A.M.C.
Rosenberg, J.		
Ross, John Hampden	Private	4th Devons (T.F.). (Died in Mesopotamia, June 5th, 1916.)

Routh, Chas. F.	Tp. Lieut.-Col.	Senior Medical Officer, 5th Southern General Hosp., Portsmouth.
Rouw, R. Wynne		Cons. Dental Surgeon attached to London Hosps.
Rowland, E. W. S.	Temp. Capt.	R.A.M.C., 3rd Southern General Hosp., in charge Reading War Hospital, No. 2.
Rowland, F. W.	Temp. Capt.	R.A.M.C.
Rowlands, R. P.	Capt.	R.A.M.C. (Surgeon to 2nd London Hosp.)
Rowlett, A. E.		Hon. Cons. Dentist to 5th Northern General Hosp.
Rudd, F. E.	Temp. Lieut.	Army Dentist.
Russell, G. H.	Temp. Capt.	R.A.M.C.
Russell, J. W.	Major	R.A.M.C. (T.F.), 1st Southern General Hosp.
Rust, A. B. Wills	Temp. Capt.	R.A.M.C. (D.), in charge of dental work at Malta.
Rycroft, E. C.	Private	2nd London Sanitary Co.
Ryle, J. A.	Capt.	R.A.M.C. (S.R.), No. 10 Clearing Station.
Salvage, J. V.	Lieut.-Col.	R.A.M.C.
Sampson, B.	Temp. Surg.	R.N., Haslar Hosp.
Sampson, W.	Capt.	R.A.M.C., 3rd London Gen. Hosp.
Samut, R. P.	Tp. Lieut.-Col.	R.A.M.C.
Sandford, H. A.	Lieut.	R.A.M.C.
Sandoe, W. A.	2nd Lieut.	9th Devons.
Saner, F. D.		R.A.M.C., Surg., Lewisham Military Hosp.
Saner, J. G.		R.A.M.C.
Sanford, D.	Temp. Capt.	Australian Transport Service.
Saul, E. R.	Lieut.	R.A.M.C., Dental.
Savatard, L.		M.O., in charge, Heyesleigh Auxiliary Military Hosp.
Saw, N. H. W.	Capt.	R.A.M.C. (S.R.), M.O., in charge, 4th Batt. Worc. Regt.
Saward, A. H. M.		Hon. Surg., Richmond Red Cross Hosp.
Sawday, A. E.	Private	Inns of Court O.T.C.
Schlesinger, E. G.	Temp. Surg.	R.N., 18th C.C.S. (Croix de Guerre, 1915, mentioned in despatches), Gallipoli and France.
Schofield, G.	Temp. Capt.	R.A.M.C.
Scott, A.	Temp. Capt.	R.A.M.C.
Scott, B. C.	Temp. Lieut.	R.A.M.C.
Scott, D. C.	Capt.	R.A.M.C. (S.R.).
Scott, E. D.		R.M.O., Queen Mary's R.N. Hosp., Southend.
Scott, Graham		Anæsthetist, Tooting Military Hosp.
Scott, P. D.	Temp. Lieut.	R.A.M.C.
Seabrooke, Alec	Capt.	R.A.M.C. (Died, July 1st, 1916., in Mesopotamia.)
Searle, Chas. F.	Capt.	R.A.M.C. (T.F.), 1/4th Northamptons, Anzac, Suvla, Suez Canal.
Secretan, W. B.	Capt.	R.A.M.C. (T.F.)
Sells, H. T.		M.O., in charge, Rosherville V.A.D. Hosp.
Sells, R.	Surg.	R.N., Queen Mary's R.N. Hosp., Southend.
Sharp, H. C.	Hon. Surg.	R.N. Auxiliary Hosp.
Sharpe, H.	Temp. Capt.	R.A.M.C.
Sharpe, S A.	2nd Lieut.	R.F.C.
Shearwood, A. L.	Capt.	R.A.M.C. (S.R.), 34th F.A. (Wounded at Suvla.)
Sheen, A. W.	Lieut.-Col.	R.A.M.C. (T.F.), O.C. 34th (Welsh) General Hosp.
Sheldon, T. Steele		M.O., in charge, Park Hall Camp, Oswestry.
Sheldon, T. W.	Lieut. and Adj.	R.A.M.C.
Shelswell, A. H.		
Shelton, H. L. C.	Temp. Lieut.	R.A.M.C., Royal Fusiliers Labour Batt.
Shenton, E. W. H.		Radiographer, Hampstead Military Hosp.
Shepherd, Cyril	Capt.	A.A.M.C., Reserve.
Sherris, Cyril	Capt.	R.A.M.C., 2nd Royal Irish.
Shorland, E. T.		M.O., Heywood Subsidiary Hosp.
Shorland, George	Surg.	R.N. (Killed in action on H.M.S. "Invincible" in Battle of Jutland.)
Sichel, G. T. S.	Capt.	R.A.M.C.
Silk, J. F. W.	Tp. Lieut.-Col.	R.A.M.C.
Simmins, A. G.	Surg.	R.N., H.M.S. "Bellerophon."
Simmonds, G. W.	Temp. Capt.	R.A.M.C.
Simms, Harold		Civil Dental Surg., 2nd Western General Hosp.
Simpson, G. S.	Major	R.A.M.C. (T.F.), Northern General Hosp.
Slater, W. A.	Temp. Capt.	R.A.M.C.
Small, D. F.	2nd Lieut.	Cheshire Regt.

Smart, H. D.	Temp. Capt.	R.A.M.C.	(Mentioned in despatches.)
Smedley, R. D.	Temp. Lieut.	R.A.M.C.	
Smith, A. Ayre	Capt.	R.A.M.C.	(T.F.).
Smith, A. Henry		Civilian Dentist, 3/4th Welsh Brigade R.F.A.	
Smith, Douglas W.	Capt.	R.A.M.C., 6th Manchesters.	(Killed in action, Fricourt, July, 1916.)
Smith, E. Bellingham	Capt.	R.A.M.C.	
Smith, F. M. V.	Staff Surg.	R.N., H.M.S. "Chanquinole."	
Smith, G. Warwick	Temp. Capt.	R.A.M.C.	
Smith, H. Joste	Capt.	R.A.M.C.	(T.F.), East Anglian F.A.
Smith, P.	Temp. Capt.	R.A.M.C.	(Mentioned in despatches. Military Cross.)
Smyth, W. J. D.	Temp. Capt.	R.A.M.C.	
Snell, Norris	Capt.	8th Batt. East Yorks.	(Killed in action, July 14th, 1916.)
Snow, Chas. F.	2nd Lieut.	R.F.A.	(Killed in action.)
Solomon, E. E.	Capt.	"C" Battery, 1st Anti-Aircraft Brigade.	
Soothill, Victor F.	Capt.	9th Field Co., R.E.	
Soper, G. B. S.	Lieut.	R.A.M.C., Hospital Ship "Ebani," East Africa.	
Sowerby, V. H.			
Spalding, F. L.	Temp. Lieut.	R.A.M.C.	
Spicer, A. H.	Temp. Lieut.	R.A.M.C.	
Spiller, J. E.		Civil Divisional Surg., Queen Mary's Hosp., Roehampton.	
Sprague, C. G.	Surg.	R.N., H.M.S. "Thistle."	
Spriggs, N. I.	Capt.	R.A.M.C.	(T.F.), 1/5th Northern Base Hosp.
Spurrell, Walter R.	Private	"Artists'" O.T.C.	
Stacey, J. B.			
Stamford, R. B.	Capt.	R.A.M.C.	(South African Medal and Clasps.)
Stamp, L. D.		M.O. in charge, 3rd East Lancs.	
Stansfield, T.	Temp. Capt.	R.A.M.C.	
Stanwell, W. A.	2nd Lieut.	2nd Lancs. Fusiliers.	(Killed in action, June 6th, 1915.)
Statham, J. C. B.	Lieut.-Col.	R.A.M.C.	(C.M.G.)
Starling, E. C. W.	Capt.	R.A.M.C.	(S.R.).
Starling, E. H.	Tp. Lieut.-Col.	R.A.M.C.	
Starling, H. J.		*Physician to Norfolk War Hosp.*	
Stead, C. C.		M.O., V.A.D. Hosp., Hawkhurst.	
Steele, R.		Emergency M.O. to Local Auxiliary Military Hosp., Hampstead.	
Steele, V	2nd Lieut.	13th Hampshire Regt.	
Steele-Perkins, J. S.	Temp. Capt.	R.A.M.C.	
Steinhaeuser, J. R.	Capt.	R.A.M.C.	(T.F.), R.M.O., 2nd Eastern General Hosp.
Stephen, L. H. Y.	Temp. Capt.	R.A.M.C.	
Stephens, Lockhart		County Director for Hants of British Red Cross Society.	
Stevens, T. G.	Temp. Capt.	R.A.M.C.	
Steward, F. J.	Major	R.A.M.C.	(T.F.).
Stewart, H.	Major	R.A.M.C.	(Mentioned in despatches.)
Stewart, J. L.	Temp. Capt.	R.A.M.C., Gordon Highlanders.	(Military Cross and mentioned in despatches.)
Steyn, S. S. L.	Lieut.	115th Brigade R.F.A.	
Stephenson, J.	Capt.	R.A.M.C.	(S.R.).
Stiven, F. W.			
Stohr, F. O.	Temp. Lieut.	R.A.M.C.	
Stokes, D. L.			
Stone, E. R.	Temp. Capt.	R.A.M.C.	
Stone, F. D. S.	Temp. Capt.	R.A.M.C.	
Stone, F. W.	Temp. Capt.	R.A.M.C.	
Stoner, Patrick	Capt.	A.S.C.	(At Salonika.)
Stott, H.	Capt.	I.M.S.	
Stott, M.	Temp. Capt.	R.A.M.C.	
Stout, Robert	Capt.	N.Z. Medical Corps.	
Stout, T. D. M.	Capt.	N.Z. Medical Corps.	
Stranack, W. T.	Temp. Lieut.	*Queen Victoria Rifles.*	(Wounded at Gourmecourt, July 1st, 1916.)
Strange, E. W.	Capt.	R.A.M.C.	(T.F.), 1/3rd North Midland F.A.
Stringer, L. B.	Temp. Surg.	R.N., H.M.S. "Victory."	
Strickland, W. A.			
Stuart, H. Douglas	Temp. Capt.	R.A.M.C., 8th Batt. Lincs. Regt.	(Mentioned in despatches.)

Stuart, J. A. W. ...	Lieut. ...	... R.A.M.C. (Dental). (At Salonika.)
Swan, R. H. Jocelyn ...	Temp. Capt.	... R.A.M.C.
Symns, J. L. M. ...	Capt. ...	... R.A.M.C., 88th F.A.
Symonds, Charters J. ...	Temp. Col.	... R.A.M.C. (C.B.) Cons. Surg., Royal Victoria Hosp., Netley, the Associated Red Cross and Welsh Hospitals, and the affiliated institutions.
Symonds, C. P. ...	Lieut. ...	... R.A.M.C.
Syms, G. F.	Surg. ...	... R.N.
Tait, E. S.	Lieut. ...	... R.A.M.C.
Taylor, A. S.	Temp. Capt.	... R.A.M.C.
Taylor, E. Stuart ...	Capt. ...	... R.A.M.C. (T.F.), 1/2nd London C.C.S.
Taylor, W. Bramley ...		M.O., Red Cross Society, North Surrey Division.
Taylor, W P.	Temp. Capt.	... R.A.M.C.
Telling, W. H. M. ...	Tp. Lieut.-Col.	.. R.A.M.C. (T.F.), 2nd Northern General Hosp.
Temple, P. G.	Lieut. ...	... R.A.M.C.
Thomas, A.	Major ...	... R.A.M.C. (T.F.), O.C. 266th Brigade R.F.A.
Thomas, A. M. ...	Staff Surg.	... R.N., H.M.S. "Talbot."
Thomas, C. E.	2nd Lieut.	... 5th Buffs (East Kent). (In Mesopotamia.)
Thomas, F. G.	Capt. ...	... R.A.M.C. (T.F.), Ophth. Surg., 3rd Western General Hosp.
Thomas T. Morrell ...	Temp. Major	... R.A.M.C. (T.F.).
Thomas, T. P.	Capt. ...	... R.A.M.C. (T.F.), O.C. Military Hosp., Brecon.
Thomas, W. M. ...	Temp. Lieut.	... R.A.M.C.
Thompson, A. R. ...	Capt. ...	... "Artists'" Rifles. (Passed to Reserve.)
Thompson, F. C. L. ...	Lieut. ...	... R.A.M.C. (At Salonika.)
Thompson, G. Y. ...	Capt. ...	... I.M.S.
Thompson, H. Q. F. ...		Anglo-Russian Hosp., Petrograd.
Thomson, D. A. ...	Temp. Lieut.	... R.A.M.C.
Thomson, G.	Temp. Lieut.	... R.A.M.C.
Thomson, G. Y. ...	Capt. ...	... R.A.M.C., I.M.S., No. 10 General Hosp., Mesopotamia.
Thomson, I. M. ...	2nd Lieut.	... 14th Argyll and Sutherland Highlanders.
Thorn, Harry Laurence	Lance-Corpl.	... "Artists'" Rifles. (Invalided.)
Ticehurst, C. B. ...		Recruiting Medical Officer for Lowestoft District.
Ticehurst. N. F. ...		R.M.O. in charge of Auxiliary Military Hosp., Normanhurst.
Tidd, G. M.		
Tilbury, Arthur ...	Capt. ...	... R.A.M.C.
Timpson, G. G. ...	Temp. Capt.	... R.A.M.C., 6th Clearing Hosp., France.
Tipping, H.	Temp. Lieut.	... R.A.M.C.
Todd, A. H.		Surg., King George's Hosp., and Bromley V.A.D. Hosp.
Tolhurst, St. J. A. M.	Capt. ...	... N.Z.M.C. (T.F.), H.M.N.Z. Hosp. Ship "Maheno."
Tongue, E. J.	Surg. ...	... H.M.S. "Ganges II."
Tooth, F.	Capt. ...	... R.A.M.C. (T.F.).
Totton, J.	Lieut. ...	... London Brigade R.F.A. (T.F.).
Townrow, V.	Temp. Capt.	... R.A.M.C.
Townsend, T. A. ...	Capt. ...	... R.A.M.C. (T.F.), London F.A.
Tracey, H. E. H. ...	Temp. Capt.	... R.A.M.C.
Trail, D. H.		Civil Surg., Military Hosp., Falmouth.
Traill, A.	Temp. Lieut.	... R.A.M.C.
Traill, Kenneth R. ...	Lieut. ...	... Royal Berkshire Regt. (Killed in action, July 1st.)
Tressider, M. E. ...		War Office Secret Service.
Trounce, T. R. ...	Temp. Capt.	... R.A.M.C.
Tubby, A. H.	Colonel	... A.M.S. (C.M.G.) (Mentioned in despatches.) Cons. Surg. to British Mediterranean Ex. Force in Egypt.
Tuck, E. S.	Fleet Surg.	... R.N., H.M.S. "Natal."
Tucker, P. A.	2nd Lieut.	...
Turner, A. H.	Temp. Lieut.	... R.A.M.C.
Turner, A. Scott ...	Temp. Capt.	... R.A.M.C., 5th East Surrey.
Turner, Fulham ...	Capt. ...	... R.A.M.C., Adjutant, Fargo Hospital.
Turner, H. M. S ...	Capt. ...	... R.A.M.C. (Major, Falkland Islands Volunteer Corps.)
Turner, J. Sidney ...		Military Representative, Penge Tribunal.
Turner, Philip	Major ..	... R.A.M.C.
Turner, Thos.	Surg. ...	... R.N.V.R.
Turner, W. A.	Surg. Prob.	... R.N.V.R.
Turner, W. H.		
Tyson, Wilson	Capt. ...	... R.A.M.C. (T.F.).

Uhthoff, J. C.		M.O. to Brighton Red Cross Hosp.
Underwood, A. B. G. ...	Surg. ...	... R.N.
Underwood, R. Murray	Private	... Artillery, O.T.C.
Vallance, H.		Bacteriologist, Laboratory, Military Hosp., Colchester.
Vance, W. J.	Temp. Lieut. ...	R.A.M.C.
Vander-Spuy, D. C. ...		
Veale, R. McKenzie ...	Temp. Lieut. ...	A.M.S., Dental Surg., Scottish Commands.
Vicars, F. G.	Lieut.	
Vicary, W. P.	Temp. Surg. ...	R.N., H.M.S. "Liverpool."
Vidot, S.		
Visick, H. C.		Hon. Dentist, Fairfield Court Red Cross Hosp., Eastbourne.
Wacher, H.	Temp. Capt. ...	R.A.M.C.
Waghorn, L. P. ...	2nd Lieut. ...	Berks Regt. (Killed in action.)
Waight, H. G.		
Wain, D.	Temp. Capt. ...	R.A.M.C., No. 3 C.C.S.
Walker, A.	Capt.	R.A.M.C. (T.F.), 85th Provisional Batt.
Walker, James	Major	R.A.M.C.
Walker, Josiah	Capt.	R.A.M.C. (T.F.).
Wallace, J. H. ...		M.O., Hospital du Casino, Fecamp.
Waller, M. J. T. ...	Temp. Lieut. ...	R.A.M.C., 91st F.A.
Wallis, F. R.	Lieut.	R.A.M.C., 3rd Southern General Hosp., Oxford.
Wallis, Herbert ...	Lieut.	R.A.M.C. (D.), Dent. Surg. to R.N.D., Blandford Camp.
Wallis, T. R.	Temp. Capt. ...	R.A.M.C.
Wallis, V. M.	Lieut.	R.A.M.C. (T.F.), Eastern Midland Brigade F.A.
Wallis, W.	Temp. Capt. ...	R.A.M.C.
Wallis, W. E.	Temp. Capt. ...	R.A.M.C. (Wounded.)
Walters, W. J.		
Ward, P. H.	2nd Lieut. ...	Northern Rhodesia Volunteer Force.
Warlow, F.		Civil Dentist to Wessex R.E., Hon. Dentist to Red Cross Hosp., Christchurch.
Warner, Cuthbert ...	Temp. Surg. ...	R.N.
Warrick, R. W. ...		
Watkin, J. P.		M.O. in charge, 9th Australian A.S.C.
Watkin, P. J.	Temp. Capt. ...	R.A.M.C.
Watney, H. A.	Temp. Capt. ...	R.A.M.C., 9th Cavalry Field Ambulance.
Watson, C. E. S. ...		West African M.S., Cameroons. (Mentioned in despatches.)
Watson, C. T.	Lieut.	
Watson, D. P.	Tp. Lieut.-Col..	R.A.M.C., O.C. 48th F.A.
Watt, N. L.	2nd Lieut. ...	King Edward's Horse.
Watts, H.	Capt.	I.M.S.
Way, Montague ...	Capt.	R.A.M.C., 29th Stationary Hosp., Salonika.
Webb, A. E.	Temp. Lieut. ...	R.A.M.C. (Dental).
Webb, H.	Temp. Capt. ...	R.A.M.C.
Webb, S. J. F. ...	Capt.	R.A.M.C. (D.), Travelling Dent. Surg. Insp., Western Egyptian Frontier Force.
Webb, W. Leslie ...	Temp. Capt. ...	Uganda Med. S.
Webber, A. M.	Temp. Lieut. ...	R.A.M.C., 27th General Hosp., Cairo.
Webster, E. M. ...	2nd Lieut. ...	Royal Berks. Regt. (Killed.)
Webster, V. T.		Hon. Surg., Red Cross Hosp., Aberdare.
Wedd, Bernard H. ...	Capt.	R.A.M.C., M.O. Royal Engineers. (Mentioned in despatches.)
Weller, C.	Temp. Capt. ...	R.A.M.C., 3rd Cavalry Divn.
Welton, F. E.	Temp. Leut. ...	R.A.M.C. (Dental).
Wenyon, C. M	Tp. Lieut.-Col..	R.A.M.C. (In Egypt.)
Wernet, A. J.	Staff Surg. ...	R.N., H.M.S. "Canopus."
Westlake, B. B. ...	Temp. Capt. ...	R.A.M.C., St. Patrick's Hosp., Malta.
Whatley, J. L.	Temp. Lieut. ...	R.A.M.C.
Wheeler, F. J.	Temp. Capt. ...	R.A.M.C., 16th Batt. King's Liverpool Regt.
Wheldon, G. W. ...	2nd Lieut. ...	5th Batt. Royal Fusiliers.
Whelpton, L. G. ...		
Whitcombe, D. M. P. ...	Temp. Surg. ...	R.N.
White, Ernest	Capt.	R.A.M.C. (T.F.), 2/3rd West Riding F.A.
White, W. Hale ...	Lieut.-Col ...	R.A.M.C. (T.F.), Chairman and Cons. Phys., Queen Mary's R.N. Hosp., Southend, and Phys., King Edward's Hosp.

Whitty, C. J.		Hon. Phys., Bath War Hosp.
Whitworth, H. P. ...	Capt.	R.A.M.C.
Wickenden, S.	Capt.	R.A.M.C. (S.R.), 45th C.C.S.
Wilkes, J. H.	Saddler Sergt.	"A" Battery, H.A.C.
Wilkinson H. B. ...	Temp. Lieut. ...	R.A.M.C.
Willan, G. T.	Tp. Lieut.-Col..	R.A.M.C. (T.F), Commanding 82nd F.A., Salonika Force.
Willan, R.	Capt.	R.A.M.C., Welsh F.A.
Willan, Richard ...	Staff Surg. ...	R.N., H.M.S. "Phæton."
Williams, A. D. J. B.	Capt.	R.A.M.C. (T.F.).
Williams, A. E. ...	Capt.	R.A.M.C. (T.F.).
Williams, G.		Dental Surg. to Military Hosp., Bangor, and Bodlondeb Red Cross Hosp.
Williams, G. T. ...	Tp. Lieut.-Col..	R.A.M.C., Home Counties F.A.
Williams, J. H. ...	Cadet	2nd Batt. "Artists'" Rifles
Williams, W. A. H. ...	Temp. Lieut. ...	A.S.C.
Williams, W. R. E. ...	Major	R.A.M.C.
Williamson, G. C. ...		
Willis, G. P. W. ...		Pioneer, Chemical Section, R.E.
Wills, A.	Temp. Lieut. ...	R.A.M.C., British Red Cross Hosp., Netley.
Wills-Rust, A. B. ...	Temp. Capt. ...	R.A.M.C., Military Hosp., Malta.
Wilson, A. R.	Lieut.-Col. ...	R.A.M.C. (T.F.), 3rd Welsh Field Amb. (Wounded.)
Wilson, O. R. L. ...	Temp. Capt. ...	R.A.M.C.
Wilson, T.	Lieut.	
Wilson, W.	Hon. Lieut. ...	R.A.M.C.
Winckworth, H. C. ...	Major	R.A.M.C.
Winter, T. B.	Lieut.-Col. ...	R.A.M.C.
Withers, S. A.	2nd Lieut. ...	3rd Lancashire.
Witts, C. J.	Temp. Lieut. ...	R.A.M.C.
Wood, C. A.	Capt.	I.M.S., 1/4th Gurkhas.
Wood, F. T. H. ...	Capt.	R.A.M.C. (T.F.), Home Counties Div. Sanitary Section.
Wood, G. E.	Dental Surg. ...	R.N.
Woodroffe, B. C. ...		
Worster-Drought, C. ...	Lieut.	R.A.M.C.
Worthington, S. ...		In charge of Red Cross Hosp., Warwick.
Wotton, W. H.	Temp. Capt. ...	R.A.M.C. (Dental).
Wright, C. S. E. ...	Temp. Capt. ...	R.A.M.C.
Wright, G. A.	Tp. Lieut.-Col..	R.A.M.C.
Wright, J. A. S. ...		
Wright, T. J.	Lieut.	R.A.M.C., Wessex C.C.S.
Wyatt, H. D.	2nd Lieut. ...	R.A.M.C., 12th Batt. Yorkshire Regt.
Wylie, A	Temp. Capt. ...	R.A.M.C.
Wylie, David T. ...		M.O. 1st Military Hosp., Cowley, Oxon.
Yerbury, E. O. ...	Private ...	"Artists'" Rifles.
Young, F.		
Young, J.	Lieut.-Col. (Tp. Col.)	R.A.M.C. (T.F.), Asst. Director of Med. Services, South Midland Divn.
Young, J.	Temp. Capt. ...	R.A.M.C.
Young, W. A.	Temp. Capt. ...	R.A.M.C.

List of Honours.

C.B.

Burghard, Temp. Col. F. F., R.A.M.C.
Luce, Col. R. H.

C.M.G.

Atkins, Temp. Col. John, R.A.M.C.
Humphry, Lieut.-Col. L., R.A.M.C.
Rawnsley, Col. G. T., A.M.S.
Statham, Lieut.-Col. J. C. B., R.A.M.C.
Tubby, Col. A. H., A.M.S.

D.S.O.

Bagshawe, Major H. V., R.A.M.C.
Bird, Lieut.-Col. J. W., R.A.M.C.
Crawford, Lieut.-Col. V. J., R.A.M.C.
Evans, Lieut.-Col. C. R., R.A.M.C.
Horton, Major J. H., I.M.S.
Lauder, Temp. Capt. J. L.
Leckie, Capt. Malcolm, R.A.M.C.
Osburn, Temp. Lieut.-Col., R.A.M.C.
Pilcher, Lieut.-Col. E. M., R.A.M.C.
Richards, Temp. Capt. Owen, R.A.M.C.

The Order of St. John of Jerusalem.

Griffiths, Lieut.-Col. Charles T., R.A.M.C. (Hon. Associate).
Ninnis, Temp. Surg. R. P., R.N. (Esquire).

M.C.

Douglas, Capt. Chas. Gordon, R.A.M.C.
Fry, Capt. W. K., R.A.M.C.
Godding, Temp. Capt. H. C., R.A.M.C.
Griffin, Temp. Capt. E. H., R.A.M.C.
Kelsey, Lieut. W.
Manfield, Capt. G. H. H., R.A.M.C.
Minns, Capt. A. H., R.A.M.C.
Minns, Capt. H. N., R.A.M.C.
Minns, Capt. W. Noel, R.A.M.C.
Pallant, Temp. Capt. H. A., R.A.M.C.
Smith, Temp. Capt. P., R.A.M.C.
Stewart, Temp. Capt. J. L., R.A.M.C.

Other Distinctions.

Bearblock, Fleet-Surg. W. J., R.N. Medal for Falkland Islands Battle.

Griffiths, Lieut.-Col. Charles T., R.A.M.C. Territorial Decoration.

Nicholson, Temp. Major, C. R., R.A.M.C. Order of St. Sabe, 5th Class, by King of Serbia.

Schlesinger, Temp. Surg. E. G., R.N. Croix de Guerre, 1915.

Mentioned in Dispatches.

Andrews, Temp. Capt. J. A., R.A.M.C.
Atkins, Temp. Col. John, R.A.M.C.
Bagshawe, Major H. V.
Barnes, Temp. Lieut. J. E., R.A.M.C.
Barron, Major R. M., I.M.S.
Brown, Major R. T., R.A.M.C.
Burghard, Temp. Col. F. F., C.B., R.A.M.C.
Burney, Capt. W. H. S., R.A.M.C.
Coplans, Capt. M., R.A.M.C. (Twice).
Costobadie, Temp. Lieut. H. P., R.A.M.C.
Digby, W. E. S., West African Medical Service (Cameroons).
Douglas, Capt. Chas. Gordon, M.C., R.A.M.C.
Dunbar, Temp. Lieut. C. G., R.A.M.C.
Galloway, Lieut. and Temp. Surg. W. D.
Gray, Major A. C. H., R.A.M.C.
Greene, Capt. C. W., R.A.M.C.
Griffin, Temp. Capt. E. H., M.C., R.A.M.C. (Twice).
Hall, Col. A. W., A.M.C.
Hamilton, Temp. Surg. Geo., R.N.
Hancock, Temp. Capt. A .C., R.A.M.C.
Hull, Major A. J., R.A.M.C.
Hunt, Capt. G. H., R.A.M.C.
Lewis, Major R. P., R.A.M.C.
Marshall, Temp. Capt. E. S., R.A.M.C.
Millett, Lieut. H., Roy. Marines (R.N.D.).
Minns, Capt. A. H., R.A.M.C. (Twice).
Montgomery, Capt. R., R.A.M.C.
Moore, Capt. J. Y., R.A.M.C.
Mumford, Temp. Capt. W. G., R.A.M.C.
Osburn, Temp. Lieut.-Col. A. C., D.S.O., R.A.M.C.
Ozanne, Major R. C., R.A.M.C.
Pallant, Major S. L., R.A.M.C.
Phillips, Capt. E., R.A.M.C.
Reinhold, Capt. C. H., I.M.S.
Richards, Temp. Capt. Owen, D.S.O., R.A.M.C.
Richardson, Lieut.-Col. H., R.A.M.C.
Roberts, Temp. Capt. C. S. Lane, R.A.M.C.
Schlesinger, Temp. Surg. E. G., R.N.
Smart, Temp. Capt. H. D., R.A.M.C.
Smith, Temp. Capt. P., M.C., R.A.M.C.
Stewart, Major H., R.A.M.C.
Stewart, Temp. Capt. J. L., M.C., R.A.M.C.
Stuart, Temp. Capt. H. Douglas, R.A.M.C.
Tubby, Col. A. H., C.M.G., A.M.S.
Watson, C. E. S., West African Medical Service
Wedd, Capt. Bernard H., R.A.M.C.

Summary of Honours.

C.B.	2	Military Cross	12
C.M.G.	5	Other Distinctions	4
D.S.O.	10	Mentioned in Dispatches	46
Order of St. John of Jerusalem	2	Total	81

Dulce et decorum est pro patria mori.

Ball, Malcolm, Lieut. Died of wounds, Mesopotamia, April 10th, 1916.

Bearblock, W. J., Fleet-Surg., R.N. Killed in action, H.M.S. "Invincible."

Beard, F. G. V. Killed in action in France, July, 1916.

Berry, P. H., Lieut., R.A.M.C. Drowned in attempting to save another man.

Browne, W. Denis, R.N.V.R. Killed in action, June 7th, 1915.

*Clifford, A. C., Second Lieut., 3rd Dragoon Guards. Killed in action, Ypres, June 1st, 1915.

Dinan, Geo. A., Second Lieut., Roy. Dublin Fusiliers. Killed in action, September 9th, 1916.

Evans, J. E. Rhys. Killed in action, Dardanelles.

Faulks, Edgar, Lieut., R.A.M.C. Died in France, September 27th, 1915.

Gough, Bernard B., Lieut., R.A.M.C. Killed in action in Belgium, Feb. 17th, 1916.

Hartnell, E. B., Temp. Capt., R.A.M.C., London Mounted Brigade. Died at Cairo, April 24th, 1916.

Hayward, M. C., Capt., R.A.M.C. Died, August 23rd, 1916 (wounded at Ypres).

*Hogben, H. F. T., Lieut. Killed in action whilst serving in Mesopotamia on November 23rd, 1915.

*Hopkins, H. L., Lieut., R.A.M.C. Killed whilst serving in France, September 9th, 1914.

James, J. S. H., Lieut. Killed in action.

Kynaston, A. E. F., Surg., R.N. Died.

*Leckie, Malcolm, Capt., R.A.M.C. Died of wounds at Frameries, August 28th, 1914

Llarena, E. F., Second Lieut. Killed at Ypres

Logan, F. T. B., Hon. Surg., Foye House Red Cross Hospital. Died.

*Lowe, F. A., Lieut., R.N.V.R. Killed in action, Gallipoli, June 4th, 1915.

*Miller, G. S., Temp. Capt., R.A.M.C. Killed in action.

Monk, G. B., Second Lieut., 2nd Battalion Roy. Warwicks. Killed in action, December 14th, 1914.

*Moore, Lionel W., Lieut. (acting Capt.), Gloucester Regiment. Killed in action, 29th August, 1916.

Morrish, D. B., Second Lieut., K.O.Y.L.I. Killed in action in France.

*Neely, Hugh B., Second Lieut., 3rd Battalion Suffolk Regiment. Killed in action, Ypres, April 25th, 1915.

Nichols, W. H., Capt. R.A.M.C. Killed accidentally in India, February 22nd, 1916

Pearce, Dudley George, Captain, East Kent (Buffs). Killed, September 3rd, 1916.

Peatfield, S. J., Second Lieut., Berkshire Regiment. Died of wounds, July 16th, 1916

*Pern, Montagu, Lieut., R.A.M.C. Killed in action, May 9th, 1915.

*Pryn, Wm. R., Lieut., R.A.M.C. Died in Belgium, June 27th, 1915.

Pryor, W. R., Lieut., R.A.M.C. Died on service in France.

Robertson, J. C., Second Lieut. (Cameron Highlanders). Missing (believed killed)

Ross, John Hampden, Private, 4th Devons, T.F. Died in Mesopotamia, June 5, 1916

*Seabrooke, Alec., Capt., R.A.M.C. Died in Mesopotamia, July 1st, 1916.

Shorland, George, Surg., R.N. Killed in action on H.M.S. "Invincible" in Battle of Jutland.

Smith, Douglas W., Capt., R.A.M.C., 6th Manchesters, Killed in action, Fricourt, July, 1916.

Snell, Norris, Capt., 8th Battalion, E. Yorks. Killed in action, July 14th, 1916.

Snow, Charles F., Second Lieut., R.F.A. Killed in action.

Stanwell, W. A., Second Lieut., 2nd Lancs. Fusiliers. Killed in action, June 6th, 1915.

Traill, Kenneth R., Lieut., Roy. Berks. Regiment. Killed in action, July 1st.

*Waghorn, L. P., Second Lieut., Roy. Berks. Regiment. Killed in action.

Webster, E. M., Second Lieut., Roy. Berks. Regiment. Killed.

* Portraits of these have been reproduced and published by the Gazette. Back numbers containing such portraits can be obtained on application to The Manager, Gazette Office, Guy's Hospital, S.E.

Captain GEORGE SEFTON MILLER, R.A.M.C.

Killed in France, September 8th, 1916.

Obituary.

GEORGE SEFTON MILLER,

Killed in France, September 8th, 1916.

George Sefton Miller entered Guy's in October, 1907, from the Colfe Grammar School, having passed the Senior Cambridge Local in December, 1906. In 1910 he passed the 2nd M.B. Lond and the 1st F.R.C.S., and in the same year gained the Junior Proficiency Prize and the Sands-Cox Scholarship in Physiology. Entering the wards, he dressed to Mr. Stewart and Mr. Dunn, was Clinical to Dr. Hale White and Dr. Pitt, Assistant House-Surgeon to Mr. Rowlands, and, finally, House-Surgeon to Sir Arbuthnot Lane from August, 1913, to January, 1914. After this he acted as Resident Medical Officer at Lambeth Infirmary for 15 months and attended Guy's weekly as Chief Clinical Assistant in the Throat Department, and during this time worked for and passed the Final F.R.C.S. (December, 1914); as he was then only in his 24th year he could not get this Diploma which was granted him as recently as May, 1916.

In spite of doing so much work during the six and a quarter years he spent at Guy's, and attaining so brilliant an examination record, he managed to find time for other interests, and while in the Dissecting Room was one of the chief lights in the Physiological Society, while later he constantly spoke before the Debating Society, where we chiefly remember his delight in a whimsical defiant attitude on the unpopular side; for some time he served on the Gazette Committee.

A satirical vein ran through and sharpened his sense of humour, as when he wrote of his Military duties in a certain place as consisting of waiting in a room all morning in case orders might arrive, and then being let off to amuse himself in a town where there was nothing to do!

Miller stayed in London until he had passed the Final Fellowship, for he had gone to Lambeth with the object of having time to work for this examination while increasing his clinical experience, and in April, 1915, took a commission in the R.A.M.C., and was promoted Captain a few months before his death.

On joining he was for a short time attached to the Cambridge Hospital, Aldershot, and then, after acting temporarily as a regimental M.O., was detailed to No. 1 Field Ambulance and remained with it till his death, which occurred at High Wood; he was buried near Mametz.

It was the writer's privilege to know Miller both as a junior and senior student; as a House-Surgeon his characteristic qualities were a keen interest in his work and a thorough spirit of enquiry into the nature of his patients' maladies. Being only 22 at this time he naturally lacked some of the advantages which more mature years give to a man in such positions, but Miller had confidence in himself, and this with his reserved manner went far to make his patients have confidence in him. He had done so well in his career at Guy's and had so abundantly during the clinical period fulfilled the promise of his early years that the future must have held many good things for him. He had the capacity of making and keeping a few good friends but not of knowing a large number of acquaintances, yet when he came to the Residents' table he was found to hide behind a shy reserved manner a cheery spirit, and he enjoyed a rubber of bridge or a game of poker with as much zest as he put into the more serious affairs of life.

His father writes that his affection for Guy's and Guy's men was particularly marked, and that he had often thanked him for sending him to us; this will help us to bear his loss, and on our side we are sure that, as the following

correspondence shows, the reputation of Guy's was quite safe in his hands, for in his life he acted up to what he felt.

The following account has been received from a brother officer of the circumstances in which Captain G. S. Miller met his death :—

"He was in charge of a large party of stretcher bearers at the time, and as it happened I was under his command. A local attack was taking place which, of course, attracted very fierce retaliation on the part of the enemy artillery.

Long before the enemy bombardment had abated he expressed his intention of taking two squads of stretcher bearers up to the regimental aid posts to bring down any wounded men he could find. At about 9 p.m. on the 8th September he started out with these eight men from our little post about a quarter of a mile behind the fire trenches, and he must have been killed about a quarter to ten.

The regimental aid post was situated practically in the front line trench, and was subsequently blown in by enemy shell fire. While on his way back he was helping a stretcher bearer to lift a wounded man out of a trench into the open when a shell came which killed him, also the patient and the stretcher bearer. Death appears to have been instantaneous. As soon as the news came of his death, a staff sergeant and a sergeant went out and brought him in and sent word to me that he had been killed. When he was brought in he had a smile on his face, so we think he can have felt no pain. No words can express to you the inferno of shells and bullets into which he went in the discharge of his duty. He was one of the bravest men I have ever met, and he was extremely popular with both officers and men, and we all are very grieved about his death.

He was brilliantly successful in his work, a splendid officer and a charming friend.

I hope I have made it clear to you that he died a most noble death in the fearless execution of his duty."

Another officer writes :—

"He was a good officer, a brave man and a warm-hearted friend. On the last occasion on which I saw him he had ridden some ten miles to see if he could do anything for me. His courage was such that he had made personal application to be transferred to the most exposed position that a M.O. can obtain, that of Regimental M.O., so soon as he realised that his own post was comparatively safe."

September 10th, 1916.

Dear Mr. Miller,—I am writing to express the very deep regret we all in No. 1 Field Ambulance feel at the death of your son, George, who was killed in action on the night of the 8th inst. I know you will be consoled somewhat in knowing that your son gave his life in an effort to save others, at a time when he was assisting and encouraging stretcher squads in a very heavily shelled area, He could not have died a nobler death. We all feel we have lost a very great friend, and I know I have lost a most valuable officer whose professional knowledge and general administrative power it will be difficult to replace. I know Captain Donald and the Reverend Bourchier are writing to Mrs. Miller. George is buried near the village of Mametz. He was killed in a trench close to High Wood. My sincerest sympathy to you and your family.

Yours very sincerely,
T. J. WRIGHT,
Lt.-Col., RAMC.

MILWARD CECIL HAYWARD,

M.B., B.C. Cantab., M.R.C.S., L.R.C.P. Lond.,
Captain, Royal Army Medical Corps (T.F.).

Captain M. C. Hayward, who died from acute septic pneumonia at Brighton on August 23rd, was the second son of the late Henry Hayward, of Queen Anne Street, London, by his second

marriage. He was educated at Epsom, Cambridge, and Guy's Hospital. He graduated B.A. in 1893, M.A. in 1898, and M.B. and B.C. in 1903. He also took the English double qualification in 1898. He filled the post of Clinical Clerk at the Samaritan Hospital for Women, House Surgeon and House Physician at Paddington Green Children's Hospital, and Resident Medical Officer at the North-West London Hospital, afterwards setting up in practice in Abingdon in 1902. At the time of the Boer War he was appointed Civil Doctor to the Guards at Windsor, and he volunteered at the beginning of the present war with a good deal of official experience. He joined the 3rd Home Counties Field Ambulance on December 3rd, 1914, and after recovering from severe concussion was sent to France. Here shortly afterwards he was dangerously wounded, a shell hitting him in the back, and causing concussion of the spine, while a bullet pierced his lung. After being on sick leave till March 1st of this year he was sent to a military hospital, but while on duty there he succumbed to pneumonia.

Captain DUDLEY GEORGE PEARCE.

Captain Dudley George Pearce, of The Buffs, aged 25, was the son of the late George Pearce, of Bournemouth. He was educated at Dulwich College, where in 1910 he took his colours for football. He became a medical student at Guy's Hospital, and was to have taken his final examination in November, 1914. On the day of the outbreak of war, however, he enlisted as a private in the H.A.C., and left for France with the 1st Battalion of that regiment in September, 1914. He was invalided home at the end of the same year with frostbite, having taken part in some of the heaviest fighting of the war up to that period. On his recovery he received a commission as second lieutenant in the East Kent Regiment, and left again for the Front with his battalion. After much fighting and personal distinction, he was on February 23rd this year promoted on the field from second lieutenant to captain, and gazetted as such as from November, 1915.

Second Lieutenant GEORGE ALBERT DINAN.

Second Lieutenant George Albert Dinan, Royal Dublin Fusiliers, killed on September 9, was the fourth son of Mr. John Dinan, of Knockeven, Rushbrooke, Queenstown, Ireland. Born in April, 1891, he was educated at the Benedictine College, Ramsgate, and was subsequently a student of University College, Cork, and of Guy's Hospital, London. He was well known in cricket circles. He received his commission in January of this year and was gazetted to the Royal Dublin Fusiliers. There are two other brothers at the front.

Papers by Guy's Men.

Hector Charles Cameron, M.D., F.R.C.P.: The reaction of the child to a faulty environment.—*The Practitioner*, September, 1916.

Capt. John A. Ryle, R.A.M.C. (S.R.), in collaboration with Capt. Adrian Stokes, R.A.M.C.: A note on Weil's disease (spirochætosis ictero-hæmorrhagica) as it has occurred in the army in Flanders.—*B.M.J.*, September 23rd, 1916.

E. W. Ainley Walker, M.A., M.D. Oxon.: An application of drop-measuring to Widal technique—a reply to adverse criticism.—*The Lancet*, September 23rd, 1916.

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R. H. Jocelyn Swan, M.S. Lond., F.R.C.S.: A bone drill.—*B.M.J.*, September 30th, 1916.

Kenneth Goadby, M.R.C.S., L.R.C.P., D.P.H. Cantab.: An enquiry into the natural history of septic wounds (Section II.) Vaccine therapy.—*The Lancet*, September 30th, 1916.

C. D. Wallis, L.D.S.: Dental inspection and treatment of school children in the County of West Sussex.—*Dental Record*, October, 1916.

Quackery and the Ethics of Journalism.

By HENRY SEWILL.

[Reprinted from *The Medical Press and Circular*, August 23rd, 1916.]

In the course of the series of letters which I recently contributed to *The Medical Press and Circular* on Medical Law Reform, I repeatedly referred to the position of the newspaper press in this connection; and I promised to add at the end a paper as fully as possible explanatory of the whole matter. I now attempt to fulfil my promise.

It was about the year 1871 that my attention was first attracted to the attitude and conduct of the newspaper press with regard to medical and other fraudulent advertisements. The fraudulent, cruel, and murderous character of medical quackery, including the sale of secret remedies and of curative apparatus had been made abundantly clear to me by private and informal investigations by my colleagues and myself at the West London Hospital. This inquiry was originated by an episode in the hospital. A woman was brought in with cancer of the breast. At this date Lister was engaged in working out his early experiments in Glasgow, and no system of antiseptic surgery had been formulated. The poor woman's case was quite beyond relief by the surgery of that date. She informed us that she had not consulted a medical man, but had relied all along upon one of the most advertised heal-all ointments of the day. This was merely a compound of coloured lard. She was sent away to die. I visited at her home, and the sadness of the case made the deepest possible impression upon me. It made me realise at once what I had never seen before, namely, the cruelty of the quack medicine trade. The case was much discussed by my friends on the staff, and most of them took some trouble afterwards to look out for similar cases. They were found in numbers in every department. I possessed written records of a great number, but these were destroyed on my retirement from London 25 years ago. The enormous increase in quackery since that date has vastly multiplied the number of victims. In every great hospital there are constantly to be found patients with simple diseases rendered chronic or with serious diseases brought to a mortal phase whilst the patient has been relying upon some worthless cure. Evidence on this point was given by enough witnesses before the Select Committee on Patent Medicines; at least a dozen more were prepared to come forward, and many scores were besides available.

The evidence of these witnesses is printed verbatim in the Minutes of the Report. Perhaps the most striking was that given by Sir Malcolm Morris and Dr. Whitfield. They declared that it was quite common to meet with patients in hospital suffering from advanced lupus, the disease having progressed to an incurable stage while these poor persons had been treating themselves with one or other of the advertised skin remedies, mostly ointments composed merely of coloured paraffin. Lupus is, in its early stages, curable. In its advanced stages it presents a spectacle of human misery enough almost to soften the heart of the Foul Fiend himself, and it is perhaps possible that some of the wretches, who for greed bring about such a calamity, are not really aware of the mischief they are working.

It would be unjustifiable to suggest that newspaper proprietors who freely admitted puffs of these quackeries before the appearance of the Select Committee's Report, were all aware of the terrible results which so often developed; but it is certain that they nearly all were aware of the foulness of the business whose profits they were sharing. The issue of the Select Committee's Report nearly two years ago has destroyed any further plea of ignorance.

As soon as I fully recognised that the newspaper press formed the main agency whereby quackery was made successful, and whereby the prospects of Medical Law Reform were mainly held up, I did my best to expose the abuse publicly and in the profession. At the Annual Meeting of the Reigate Division of the British Medical Association in May, 1909, I gave an address on "Medical Law Reform and the Newspaper Press." After discussion, the following resolutions were carried unanimously:—

"The Reigate Division would urge upon the Council of the British Medical Association the necessity of including the traffic in quack medicines and apparatus within the scope of the proposed Royal Commission; and in view of the fact that this fraudulent and cruel trade is carried on mainly by means of advertisements, the Division would further urge upon the Council the necessity of bringing the facts at once forcibly before newspaper proprietors."

"That the resolution, and a summary of Mr. Sewill's speech introducing it, be printed and sent to the members of the Division, to the other Divisions in the S.E. Branch, and to other members."

In 1910 a prominent London weekly paper accepted from me a series of articles on Medical Law Reform. In these I discussed the conduct of the newspaper press. It was in the early seventies that I first began to write and agitate upon the question of Medical Law Reform. I constantly urged that a movement should be started in the profession to induce the Government to set up a Royal Commission to inquire into the failure of the protective clauses of the Medical Act of 1858 and into the quack nostrum and instrument traffic which formed — as it still

forms—a cloak for much unqualified practice. I wrote on the subject on every proper occasion in the medical journals. In the first years I addressed many letters to leading lay papers, not one of which letters was ever published. It is now many years since I satisfied myself that the great bulk of the newspaper and periodical press was fully alive to the nefarious character of advertisements which they were accepting. I possess a list of papers which are more or less blameless. The list is long, but forms only a small proportion of the total number of journals. Obviously I cannot publish their names. Those who wish to investigate may turn to the files of leading papers which are to be found in most clubs or public libraries. Some papers keep their pages perfectly clean; others refuse incomes which might amount to thousands by rejecting advertisements that are freely accepted by most of their brethren. It is the papers standing in the highest ranks of journalism that deserve most blame in this matter. They all set themselves up as week-day lay preachers of morality—personal, social, and political; they are the self-appointed guardians and promoters of the well-fare of the poor and protectors of the national honour. Among leading papers must be included great numbers of those published in our big towns and cities. In information and in authority and literary quality of their editorials they are not inferior to most London papers, and they exercise great influence in their own districts. With rare exceptions, inferior papers are guided by the examples of their betters. If the managers of inferior papers are questioned, they almost invariably reply that they are business firms and cannot afford to deprive themselves of the income from advertisements which appear in the great majority of high-class papers.

The Select Committee on Patent Medicines, Apparatus, and their Advertisement was set up in 1912. The British Medical Association at once appointed a committee of its own to prepare a case. I was invited to meetings of the committee, and in the end was asked to give evidence on behalf of the Association in the question of advertisements. I was instructed to prove that "the great part of the newspapers which published quack advertisements out of which they got enormous incomes were either aware of the nature of the traffic or showed great negligence, more or less culpable, in not recognising the facts which were constantly before their eyes or thrust upon them." My evidence verbatim may be found beginning at page 298 of the Minutes of the Report. I showed that the number of cases in the Criminal and Civil Courts which were published in at least the foremost papers had been more than enough during the past 25 years to expose the true character of medical quackery in every form, including the traffic in secret remedies. I have already stated that the papers would not publish letters on the subject, but many of the foremost, having medical men on their staffs, allowed their editors to stultify themselves by printing more or less frequently leaders denouncing and exposing quackery in every form, the advertisements of which were all the time appearing in their own columns. I handed in to the Select Committee a large collection of such letters, together with advertisements and puffs from the same papers. A puff differs from an ordinary advertisement. It is written in editorial language; it is printed apart from advertisements among editorial matter; it is distinguished merely by the sign "advt." at the foot in the smallest possible type, although inferior papers often leave out that distinctive mark. No man or woman of the world can be deceived by such puffs, but it must be remembered that the traps are laid, not for the clever people, but for the simple, the ignorant, the foolish, and the suffering classes.

When glaringly objectionable advertisements constantly disfigure the pages of a paper, it is impossible to believe that the editor, whilst stultifying himself occasionally in denouncing fraud, is ignorant of what his manager is doing; it is impossible to believe that the manager is unaware of what the editor is writing; and it is impossible to believe that at least the chief proprietors can be quite oblivious of the tainted source from which they are deriving needed income or amassing superfluous wealth.

The editors of some of these papers must be in a position of terrible discomfort and humiliation while, striving to do their duty, they witness helplessly the sinister game of their employers. They must see that whilst an article at more or less rare intervals denouncing quackery and fraud serves to prove the editor's knowledge, it can only confuse the ingenuous reader, to whom I have just referred, and lead him to look upon all the advertisements in such a high-toned paper as above suspicion. Nothing could better serve the ends both of the advertisers of whom I write and of the newspaper proprietors who wish to attract advertisements.

If leading newspaper proprietors were at first ignorant of the facts, they were in time fully informed upon them by the writers whom they themselves had employed, and the knowledge must have spread from the highest throughout all lower-class papers. On the occasion when I gave my evidence, the chair—in the absence of the President—of the Select Committee was occupied by a Member, a distinguished journalist. Other members present were, I believe, more or less closely associated with journalism. I was not cross-examined, and no question was put in the least degree controverting my statements. On the contrary, some kindly questions were tendered, enabling me to emphasise some of my points. For instance, I was able to press home the fact that there were journals

which, without medical editors, found it easy to exercise such discrimination that no medical advertisement in the least degree questionable was ever discoverable in their pages.

A report of the evidence at each sitting was distributed among the press; and it was quite within the power of any journalist to have presented himself in order to refute my evidence or make any explanation, but no attempt of the kind was offered.

In what it states and what it suggests, the section of the Select Committee's Report dealing with the Press and Secret Remedies entirely supports my statements. I will quote some passages. It says that "as so large a sum as £2,000,000 or more is spent annually in advertisements of these remedies in one form or another of advertising, the trade is naturally of great importance to newspaper proprietors. In the case of most newspapers, these advertisements constitute one of the most considerable sources of income, while a number of small provincial newspapers could probably hardly exist at all without secret remedy advertisements." The report goes on to state that the sum of £2 000,000 annually does not include that derived from "the advertisements of swindlers like Dr. ——, the 'eye quacks,' the 'deaf quacks,' the cancer curers, the consumption curers, the electric belt makers, the curers of rupture without operation, or 'fakirs generally." . . . "We must point out in this connection that the large sums received from the advertisement of secret remedies lead newspapers either from discretion or under compulsion to exclude from their columns criticism or discussion of secret remedies. When the British Medical Association, for example, issued their volume entitled 'Secret Remedies,' containing analyses, costs, etc., of a large number of proprietary medicines, not only was the volume not noticed editorially by most papers, but even an advertisement of it was declined by many journals, some of them of the highest class. A trial in Edinburgh, in the course of which the judge described the business of the proprietors as 'based on unblushing falsehood for the purpose of defrauding the public,' was, with few exceptions, not reported in the press, and the remedy still has a considerable sale. The extent to which criticism of secret medicines is excluded from the press may probably be judged by anyone who will take the trouble to see how much attention is bestowed by the newspapers upon your Committee's Report."

Whether it were known or not earlier, the fact was conclusively proved before the Committee that a great number of nostrum proprietors deserved to be classed among the "swindlers" and "fakirs" generally stigmatised by the Committee. Is it possible to contend that any portion of a great institution like the newspaper press ought to depend for its existence upon what is clearly connivance at fraud and participation in crime? If there are newspapers which cannot be kept alive without such support, they surely should be left to perish; and where can be found defence for the conduct of newspaper corporations or individual proprietors who devote themselves to piling up wealth from these polluted sources?

The above citation from the report challenged the newspaper press to notice it; the challenge was entirely ignored by all save an insignificant minority. It is impossible to doubt that every responsible newspaper manager has been made fully alive to the facts of the case since the publication of the Select Committee's Report, and yet there has been no diminution in the abuses exposed. A proportion of the newspaper press as numerous as ever still fills its columns with advertisements and puffs which to the view of every manager and proprietor display the word fraud writ large across their faces. Towards the end of the report the Committee named a long list of cures, not only the sale, but the advertisement of which they urged ought immediately to be prohibited by law. But advertisements of these cruel impostures are still as common as ever. This surely constitutes a great scandal. The only remedy seems to lie in legislation which shall put an end to all the grosser forms of quackery, and the way to carry out the needed legislation is clearly indicated in the report. There exists now a splendid opportunity for some of our great journals to do an enormous service to the public by taking up the question of legislation against common medical imposture. At the same time they would surely succeed in removing the ugly stigma which at present disfigures the great institution to which they belong.

Chapel Notes.

After some tribulation we are glad to be back in the Chapel and to have it clean. The Vestry has been altered to make room for the last of the panels, which has been ordered from Messrs. Powell. The price has increased from £50 to £60 owing to the war.

The first Winter Meeting of the Missionary Society will be held on Monday, October 9th, at 8.15 p.m., in the Nurses' Home. The Rev. D. Christopherson, Vicar of S. Marks, Plumstead, will speak.

We are sorry to announce that Mr. Langdale has resigned the Assistant Chaplaincy and is taking up work in Bethnal Green. His work and influence will be much missed. The Bishop has appointed the Rev. C. C. Thacker to succeed him.

A Hymn of Hate,

Or, "The Livery Lieutenant's Lament."

(Can be sung to the tune of almost any Hymn.)

1

We hate these damned hostilities
That bring us to this place.
We hate the entire area,
But most of all "MY BASE."(1)
We hate the guns, both large and small,
That make a nasty din,
We hate this constant coaling,
We hate it all like Sin.

2

We hate the rain, we hate the wind,
We hate the mist and snow,
And every kind of weather
We get at "Halifax."
We hate the cursèd censoring,(2)
We hate decoding, too,(3)
We hate our four-hour watches,(4)
We loathe the General Q.(5)

3

We hate our other Messmates,
We hate them, short and tall,
Both those that talk, and those that don't,
We hate them one and all.
We hate our early morning tub,
And those that bathe with song,
Both those who splash in little baths,
And those who sleep in long.

4

We hate the daily breakfast
With a far surpassing hate,
The "Bright and Early" Messmate,
When we ourselves are late.
We hate the Wardroom servants,
The kippers and the toast,
We hate the usual buttered eggs,
But we hate the coffee most.

5

We hate the scrapping in the Mess,
We hate each broken chair,
We hate the larger table,(6)
It drives us to despair;
We hate the Man who takes to bed
A Wardroom Magazine,
And those who argue half the night
And don't say what they mean.

6

We hate the evening running round,(7)
We hate the Medicine ball,
We hate the hockey on the deck,
That shows up people's gall.
We hate to hear the Bugler
A-mutilating calls,
We'd like to get him quietly
And—tell him what we think of him.

7

We hate the Berlin puzzle
That savours of the War,
We hate the crowd who plays it,
We hate their language more.
We hate the newer version,(8)
The pubs from East to West,
That brings back recollections
Of days of GIN-ful rest.

8

We hate the Norddeich Nonsense,(9)
The Piffle in Poldhu,(10)
The local Scrap of Paper,
The London Journals, too.
We hate the map of Poland,
The Dardanelles and France,
We hate the bilge the papers gas
Of mythical advance.

9

We hate the super-gluttons(11)
Who with stout and oysters stuff,
We also hate the Glutton Club
When there is not enough.
We hate this cutting for our Gin,
We always seem to lose;
We hate these monthly wine-bills,
That tale of swallowed booze.

10

We hate the after-dinner bridge,
We hate the cards we hold,
We hate our partners for their play,
And declarations bold.
We hate the Pianolo,(12)
That grinds out tunes in jerks,
And wish the man who plays it
Were scuppered by the Turks.

11

We hate the spotting table,
That spoils our mid-day sleep,
And all this damned patrolling;
It fairly makes us weep.
We hate the Incinerator,(13)
Belching forth bones and rags,
We hate this lack of Cabins,
With its everlasting Cags.

12

We hate the days in Harbour,
We hate the days at Sea,
In fact, we're hating everything—
The whole damned A B C.
We hate ten dozen other things,
We hate them in their Twelves,
But most of all the things we hate,
WE HATE OUR MOULDY SELVES.
A. MILDEW MOULD.

(1) Hell's an improvement on this hole.

(2), (3), (4) This is what we doctors have to do.

(5) General Quarters mean battle action stations.

(6) There are three or four super mouldy merchants who sit at a special small table to get away from the rowdy element at the large table.

(7) At 4 p.m. every afternoon the whole ship's company double round the ship for half an hour, the band playing stirring tunes the nonce.

(8) Owing to the skill and cleverness displayed by our Messmates, it was thought necessary in some way to increase the difficulty of "Getting to Berlin." The mystery was solved thus: Twice as many pitfalls were added and the various holes, old and new, were named after the more famous London hostels, and the puzzle was re-christened "What a Night," or the "Rode to Ru-ine."

(9) German wireless daily news.

(10) English wireless daily news.

(11) The Glut Club starts activities a little before dinner. Sardines, anchovies, olives, etc., are laid out on the sideboard, causing a great run on "Gin" and other Y.M.C.A. drinks!

(12) Pianolo referred to was made in 1886, the year I was born! It causes more bad language than any other blessed thing on board. It's a regular perisher!

(13) Every document, paper, etc., is burnt daily on upper deck in the above. Nothing but ashes are thrown overboard!

Pass List.

Society of Apothecaries of London.

Primary Examination (Part II.)—Anatomy.

At the Examination held on October 2nd, 4th and 5th inst. the following candidates were successful:—

H. M. Brown, W. R. Carling, K. M. K. Duff, E. E. D. Gray, H. N. Shapiro,

Physiology.

H. M. Brown, W. R. Carling, K. M. K. Duff, H. N Shapiro.

Notice.

Guy's Hospital Medical School.

The following Entrance Scholarships have been awarded:—

Senior Science Scholarship for University Students.—William Gover, Balliol College, Oxford (£75); Robert Blake Poole Lansdown, B.A., Pembroke College, Cambridge (£35).

Junior Science Scholarship.—Alan McKenzie, Preliminary Science Class, Guy's Hospital (£120).

Scholarships in Arts.—Antoine Yves Cantin (Private Study) (£100); John Alexander Currie, Diocesan College Rondebosch, Cape Colony (£50).

Specialities.

Tonalka Aperient Water (Idris & Co.).

Tonalka Aperient Water (Idris & Co.) is a solution of sulphates without organic matter, with the characteristic taste of sulphate. It has the advantage over natural aperient water of being constant in composition, and over undissolved salts of being easier to take. It may be recommended as an inexpensive mild aperient. Price 1s. per bottle.

Death.

HAYWARD.—On August 23rd, at Brighton, Captain Milward Cecil Hayward, M.B., B.C. Cantab., M.R.C.S., L.R.C.P. Lond., Captain R.A.M.C.

PEARCE.—Killed in action, Captain Dudley George Pearce, The Buffs, aged 25 years.

SHADWELL.—On September 23rd, at "Ivydene," Derry Downs, St. Mary Cray, St. Clair Brockway Shadwell, M.D., of Lyndhurst, Walthamstow, Essex, aged 64.

F. A. K.
K. L. B.

GUY'S HOSPITAL GAZETTE.

VOL. XXX., No. 738.] OCTOBER 21, 1916. [SIXPENCE.

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Passim.

WITH the year slowly drawing towards its close, we can come to review the possibilities of the coming winter with a fair hope of accuracy in our prophecies, No one, whatever may have been his previously expressed views, will find cause for genuine surprise in the fact that we are still in the midst of the war period, and after the two years of so-called belated preparation there seems every indication that events and affairs are at length settling themselves along the lines of a definite course.

Both at home and afield does this appear to be the case. Perhaps we are entirely wrong in our surmise that our own hospital authorities have decided as to their exact requirements, but from their action it would seem to be the case.

Thus it follows that the duties of the junior and senior students and house officers fall easily into complete definition. With the excellent work of the remaining staff, our appreciation of which has been so often expressed, and the co-operation of the junior assistants, the running of the hospital has been extraordinarily smooth, and though our own views can only be built on a comparatively superficial observation, it appears that there is every prospect—in fact, certainty—that this state of affairs will continue. Guy's will still deal with all the work that opportunity gives her, and men will still do the best within their power to ensure the success of her efforts. It seems that for the mutual benefit of Hospital and Forces that with us, as with every similar institution, the present course is ideal, and the only condition which both necessity and duty call upon us to avoid is a redundancy of effort and skill. Carry on, but realize when a substitute is waiting to enable us to relinquish control and set out on the course that has always been our expressed intention. We have every confidence that throughout this winter and throughout the war, Guy's will firmly adhere to this principle.

WE wish to draw the attention of the Hospital to two meetings that will take place this term with reference to the National Mission of Repentance and Hope. The meetings have been arranged by the Guy's Hospital Christian Union. They are meant to appeal to a wide audience; in fact, to all those who would like to begin to think about the more serious aspects of life.

The names of the two speakers should ensure wide support among us. Dr. Craig, who will

speak on "The Meaning of the National Mission," at 8 p.m. on Wednesday, November 1st, in the College Smoking Room, needs no introduction to a Guy's audience. We, who have often heard him discourse on abnormal mental processes, will be very glad to hear him on this occasion discuss the normal.

The Rev. W. Temple, Rector of S. James', Piccadilly, who will speak on December 13th, is a man of wide interests and large experience, and is, in addition, a brilliant speaker. He is known as a profound philosopher. At Oxford he was President of the Union. He has also been an Oxford Don and Headmaster of Repton. At present he is chaplain to the King.

Dr. Craig and Mr. Temple have both been in the habit of getting to the bottom of things, and their treatment of the National Mission will be by no means on the lines of dogmatic theology. The two addresses should appeal particularly to all of us, who at this serious time are wondering what we are, what we are here for, and whither we go hence.

It need hardly be said that any old Guy's men will be heartily welcomed. Again, let us bear in mind the two dates, November 1st and December 13th.

The latest news from America is to the effect that the serious epidemic of anterior poliomyelitis, which has devastated New York and adjoining districts, is showing distinct signs of abating with the end of the hot season. By the later part of September the new cases had declined to 40 per day, and only about 15 deaths per day were notified. These numbers are sufficiently formidable, but when we realise that its ravages have accounted for victims whose number easily runs into five figures, we congratulate our American cousins on the waning of this terrible scourge.

With deepest regret we hear of the death in action of Capt. O. Parry-Jones, R.A.M.C. Many of his friends are still with us, and all will remember his excellence as a man at his work or on the playing fields. We express our sincerest sympathy to his relations and friends, and our great appreciation of the man.

As a result of the indignation of the nursing world at the Constitution of the Committee on the Supply of Nurses, the Secretary for War has announced the appointment of additional members representing the profession both military and civil. Among the names we are glad to read that of Miss L. V. Haughton, Matron of Guy's Hospital. The terms of reference are now officially given as follows:—"The Committee have been appointed for the purpose of ascertaining the resources of the country in trained nurses, and women partially trained in nursing, so as to enable it to suggest the most economical method of utilizing their services for civil and military purposes."

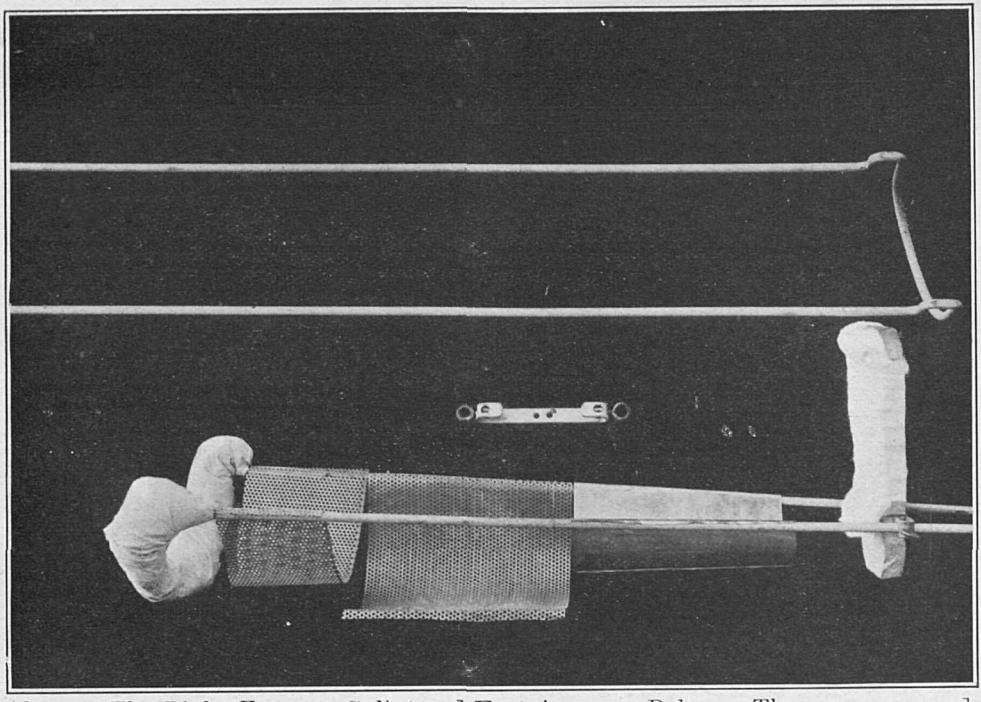
J. had been operated upon for appendicitis. During his period of convalescence he became friendly with two of his neighbours. One morning he called across "How are you feeling, boys, to-day?" To his surprise they answered together, "Not so bad considering we've had to go through a *couple* of operations!"

"How was that?" queried J., growing worried.

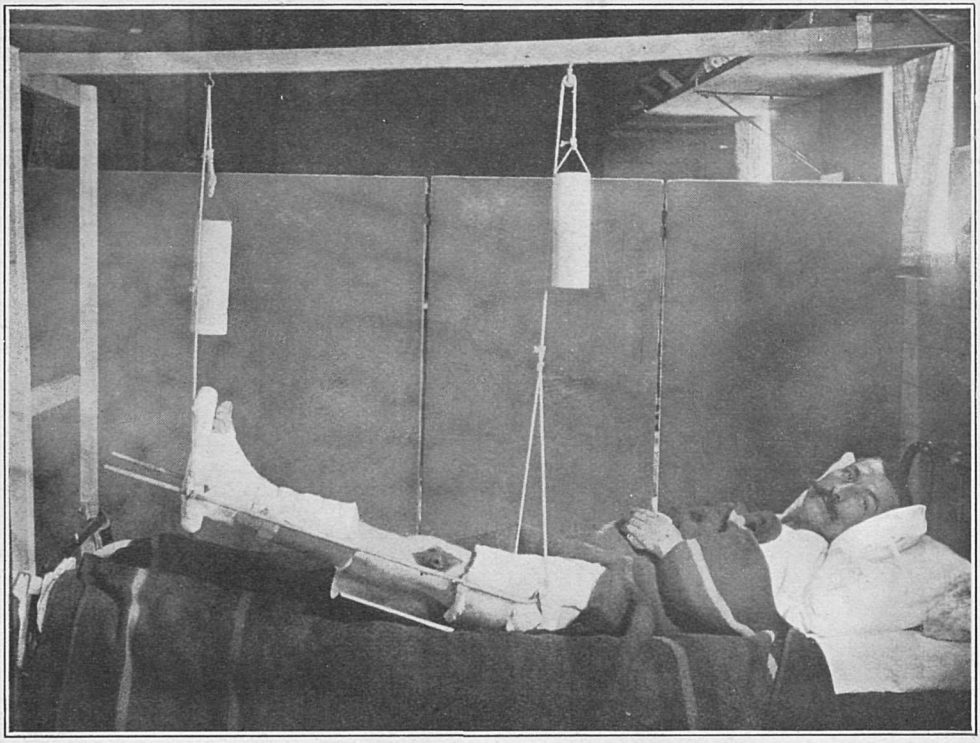
"Oh! the Surgeon! he missed a needle and a pair o' scissors. He found the needle in him and the scissors in me, so we've had two operations. But we're right enough, now!"

Just then the Surgeon's head appeared at the door as he asked, "Have you seen my silk hat anywhere, Sister?"

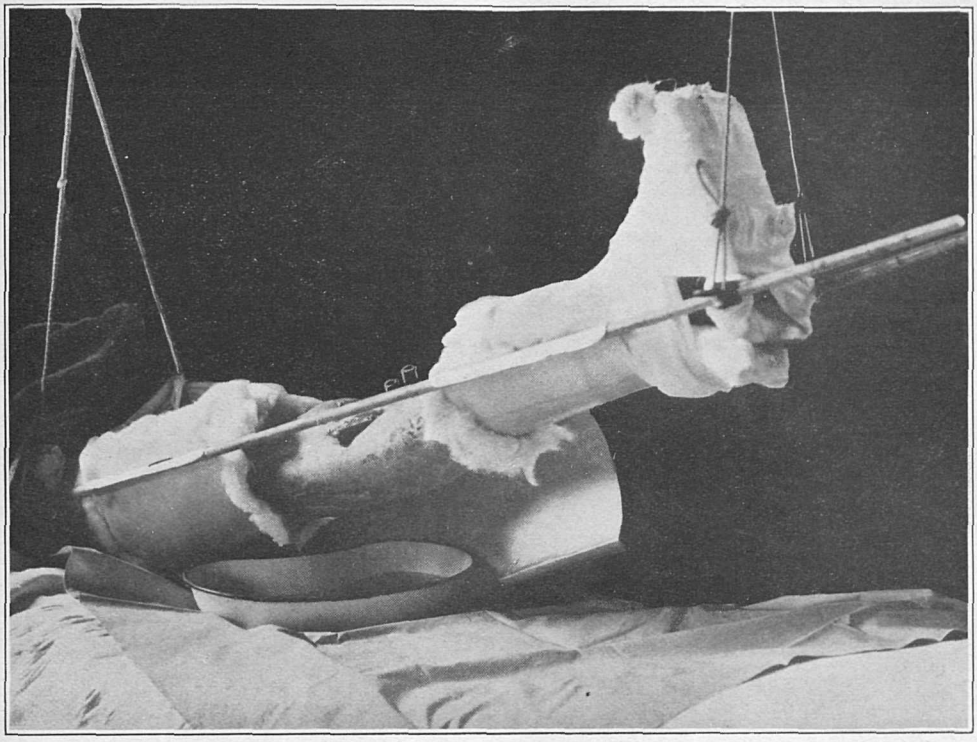
J. fainted.



1. Above.—The Blake Fracture Splint and Footpiece. Below.—The same arranged with metal sections for dressing a penetrating wound of the knee.



2. Splint in use.



3. Splint in use.

PHOTOGRAPHS ILLUSTRATING ARTICLE

— ON —

"WOUNDS OF THE KNEE JOINT."

[*See Article on page 363.*

"Somewun sick at yer 'ouse, Mister Carter?" asks Lily. "I see the doctor roun' there yesterdy."

"It was fer me bruther, Lily."

"*My!* What's 'e got wrong wiv 'im?"

"Nobody don't seem ter know. 'E can sleep, 'en eat well as ever 'e did. Sit dahn in the sun 'ere 'en look well as any on us, but 'e cahn't do no work ut all!"

"'E cahn't? Ye say 'e cahn't work!"

"Noher stroke!"

"Law, Mister Carter, that ain't no disease wot yer bruther's got! That's a gif'!"

Pass List.

Examining Board in England by the Royal Colleges of Physicians of London and Surgeons of England.

At the First Professional Examination of the Conjoint Board, held on September 26th, 27th, 28th and 29th ult., the following candidates were approved in the undermentioned subjects:—

Parts I. and II.: Chemistry and Physics.—G. C. W. Curson.

Part III.: Elementary Biology.—E. T. Lloyd.

At the Second Examination in Anatomy and Physiology, held on September 28th and 29th, and October 2nd, the following candidates were successful:—G. A. A. Bradnack, J. Kendall, K. Mullen, T. Reed, C. G. D. Siggs, P. J. Briggs.

At the First Professional Examination for the Licence in Dental Surgery, held on September 29th and 30th, the following candidates were approved in the undermentioned subjects:—

Mechanical Dentistry and Dental Metallurgy.—H. O. Holmes, F. L. King, R. M. Underwood.

Mechanical Dentistry—A. B. Aldred, A. F. Bartle, A. R. Cox, A. H. Grieve, J. James, S. E. Tweney, M. Ginsburg, A. N. Goudge.

At the Preliminary Science Examination for the Licence in Dental Surgery, held on September 26th, 28th and 29th, the following candidates were approved in the undermentioned subjects:—

Chemistry and Physics.—C. A. Marais.

Physics.—R. G. Griffiths, H. J. Lyon.

Wounds of the Knee Joint.

As you have been devoting part of your space lately to the extremely important subject of wounds of the knee-joint, I should very much like to add my experiences of these injuries. The treatment of knee wounds has interested me above any other. It is a class of work in which, perhaps, success and failure are as widely divergent as anywhere in surgery.

Wounds of the knee-joint are of special interest:—

1. Because the functional result of such an injury is of the greatest importance to the wounded man, and as regards his capacity for military or civil employment in the future.

2. Because, practically speaking, the knee is the only joint in which uncomplicated injury is met with at all frequently, and in which joint surgery proper can be studied. The same methods can be applied to other joints, but the result is apt to be overshadowed by the concomitant injury to the bones. In the knee the surfaces are of such a size, that a fair amount of bony injury can occur without prejudicing the result materially.

In discussing methods employed it is easiest to divide the wounds met with into—

A. Wounds involving the joint, without the projectile remaining in the limb, and without bony injury.

B. Wounds involving the joint, with no projectile remaining, but with injury to the bones.

C. Wounds of the joint where the projectile remains in, but there is no bony injury.

D. Wounds where the projectile remains in and the bones are injured.

E. Cases of grave bony injury to the lower limb, in which involvement of the joint is of only secondary importance. It is purposeless

to discuss this latter class. Of the five cases of which I have notes, in four the lower end of the femur was hopelessly comminuted for a length of 4 to 6 inches involving both condyles; in the fifth the upper end of the tibia was similarly pulverised.

Results to be expected.—Classes A and B differ from C and D in that in the former operative interference should be avoided unless there is a special indication, while in classes C and D operation should be the rule, the projectile only being left untouched in special instances and after careful consideration.

As regards the probable final result, however, the presence or absence of a bony injury is of more importance than the inclusion or otherwise of the projectile. Provided—and it is most important—that the limb has been efficiently immobilised during transport, and that it can be seen and operated on in 24 to 48 hours after injury, it should be nearly always possible in classes A and C to obtain a good moveable and useful knee. In classes B and D the result will vary from complete mobility to complete stiffness according to the nature of the bony injury; always provided that treatment has resulted in the joint remaining aseptic. Once a knee is infected, it means that the best result to be hoped for is a useful stiff leg, but where there is serious bony injury even partial mobility means an uninfected joint cavity.

Of course, in all of these classes there will always be many cases where wounds of other parts of the body will, by interfering with immobilisation, or by affecting the general health of the patient, prevent any hope of a more than mediocre result as regards the knee itself.

Methods.—To begin with, I believe that in the successful treatment of wounds of the knee-joint the importance of absolute immobilisation cannot be overstated. It should be complete. A back splint alone is not enough, for the foot and ankle must be kept from any movement. It should be practised as early as possible after the injury is inflicted, and during dressings, operations, or transport of the patient—until all danger of infection has been overcome—even the slightest movement of the joint is to be feared. I have found the easiest and most effective way to ensure absolute rest of the joint under all conditions is by slinging the whole limb. I have been using the iron bar splints which I saw employed by Mr. Blake at the American Hospital, Neuilly, Paris, essentially two parallel iron bars of 9 mm. diameter, joined at the upper end by a U-piece set at an angle which fits round the posterior aspect of the thigh at the level of the tuber ischii. To use them for knee cases, I fit a sliding footpiece and three semi-cylindrical sections of thin aluminium sheeting, hinging on the inner bar and clipping on the outer one. The top section supports the thigh, the lower one the calf and ankle, while the middle one when unhinged uncovers the back of the knee and enables the most extensive dressings to be done without the slightest movement. The whole is slung from a framework lashed to the bedframe, by two weights running over pulleys, one of about 4 lbs. for the upper end of the splint, and one of about 8 lbs for the footpiece; the former ensures that the splint will follow all movements of the hip when the patient sits up or goes on the bed pan, the lower weight allows the foot end to be raised or lowered at will for dressings. Suspension ensures a degree of rest far superior to that obtainable by any fixed apparatus, the whole limb being insulated from the jars and shocks which movements in the neighbourhood of the bed necessarily impart to any splint lying on it.

The value of suspension was very strikingly illustrated in a case which reached me after three days at a clearing hospital. The right knee-joint had been opened and tubes put in

on each side. X-rays showed a partial fracture of the internal condyle, with a shrapnel bullet among the fragments. The bullet was removed along with loose bone fragments, the wounds cleaned up, and the leg fixed on a long back splint with footpiece. There was, however, a profuse discharge from the wounds and œdema of the calf and foot, though no tracking was found. At the end of three weeks the leg was slung up in a sectional splint; the swelling began to disappear immediately and the discharge to diminish; in about ten days the tubes were left out, and at the end of six weeks the patient was discharged with clean granulating wounds, and a leg stiff, but of normal size.

I have had two cases (Nos. 14 and 18) in which, owing to the imperfect fixation given by a fixed splint, an infection hitherto limited to the track has after several days suddenly spread to the main cavity, converting a promising case into one of some anxiety.

With regard to operating on these cases, I feel that one's attitude should be that of *Punch* towards those about to marry—"Don't." One's chief, in fact, one's only ally, is the bactericidal action of a healthy synovia. Given fair treatment, it can tackle infection to a quite surprising extent, but once the synovia has given up hope, no surgery or antiseptics are any use. It, therefore, seems the best course :—

1. Not to touch it at all where this can be avoided.

2. When handling it, to spare in every possible way damage that aversely affects its reactive powers—

(a) Extensive cutting, retracting, or holding with clips to see into the joint.

(b) Bleeding.

(c) Application of artery forceps.

(d) Swabbing the synovial surface.

(e) Lengthy exposure.

(All these causes of injury to the synovia are reduced to a minimum if a tourniquet is applied in all operations.)

(f) Leaving any foreign body in contact with it—loose bits of bone or shell, draining tubes.

(g) The use of antiseptics.

In classes A and B mentioned above, where no foreign body remains in the joint, the only operative procedures called for are measures directed to cleaning the track. But if there is any reasonable probability of the joint cavity being uninfected, it is far better to leave it alone. It is sealed off, and any handling may break down the barrier on which alone success depends. Every case must be decided on its merits, but the resistance of the synovia to infection, especially as far as I can see to infection with the B. perfringens, is quite considerable.

In Case 34 there was a large tearing shell wound, about 8 inches by 4, of the anterior part of the right thigh, reaching down as far as the middle of the patella. There was a virulent gas infection, the exposed muscles were black and sloughing, and there was a small hole into the supra-patellar pouch through which synovial fluid was escaping. A small plug of gauze soaked in iodine was put in this while the wound was cleaned up, dead tissue cut away with scissors, and the whole cauterised with pure carbolic acid. The leg was fixed on a back splint and a small gauze plug placed over the hole in the joint. The rest of the wound was merely covered with a sterile sheet, and a few drachms of eusol poured over it every two hours for a week. The wound cleared up in a satisfactory manner. No signs of joint infection appeared, and on discharge three weeks later the joint was freely moveable.

In Case 26 three bits of bomb were removed from the right knee-joint, one just above the patella, one smashing the patella to bits, and

one entering below the patella and lying between the condyles; another bit of bomb was removed from the thigh muscles. The three knee wounds were excised and the joint completely closed. Two days later there was a gas infection of the thigh wound; I had to split the muscles widely open, and owing to its proximity I considered it safer to drain the knee-joint at the same time. Though the infection was probably the same as in the thigh wound, the knee-joint appeared absolutely clean, and contained only clear serous fluid.

In classes C and D, operation for the removal of the foreign body is necessary in the majority of cases.* If, however, having traversed the joint, it is found to be extra-articular, and at the same time is not obviously infected, it is far better to be content with fixation of the limb till all reaction has subsided. The projectile can then be safely removed aseptically at a later date.

In Case 21 there was a shell wound of the left knee, a bit about half an inch in diameter having entered above the patella and being localised in the centre of the internal condyle. There was a certain amount of fluid in the joint, but no temperature, and little pain. After a fortnight's fixation, all the fluid having been absorbed and movement being painless, he was evacuated. The bit was removed two months later in Paris with a perfect result.

In operations for the removal of foreign bodies from the knee—

1. The track is excised with knife or scissors down to the capsule, and then swabbed with 5 per cent. iodine in spirit, all obviously injured tissue being cut away. The aim of this is not the ideal one of getting rid of all bacteria, but the more practical one of robbing them of a medium on which they flourish.

2. The old instruments are laid aside, and with a new set the joint is opened and the foreign body removed. It often avoids manipulation to do this through a fresh opening. This being clean is them sutured completely, the old track being packed; its asepsis is not so sure.

3. The joint is irrigated with about two pints of 5 per cent. saline to wash out cloth, blood, bacteria.

4. The track, if large, is closed somewhat by sutures. Drains *into* the joint are inadmissible, and I have found it difficult to put a tube just down to the synovial membrane and be sure it stays there. It is simpler to approximate the membrane only and convert the track into a funnel shape with its apex at the wound in the joint. This is loosely packed with gauze soaked in 5 per cent. saline.

5. 10 c.c. ether is injected into the joint at some other part.

6. The limb is wrapped in sterilised absorbent cellulose tissue, fixed in a trough splint, and slung while the patient is still under the anæsthetic.

After this the gauze plug is moistened daily with 5 per cent. saline, and a new dressing of cellulose tissue applied. In three or four days the plug will slip out easily, and is replaced daily for about a week by a loosely-fitting wick. A fair amount of fluid will always accumulate in the joint. I have been led to avoid aspirating this—

1. Because it always recurs immediately.

2. Because it is a natural reaction, and is useful—

(a) As being the exudate by which the synovial membrane exerts its bactericidal action.

(b) Mechanically, it keeps the injured surfaces apart.

Vide Col. H. M. W. Gray: "Treatment of Gunshot Wounds of the Knee-joint." *B. M. J.*, July 10th, 1915. Page 41.

3. Because it very readily disappears when the reaction subsides, and does not remain long enough to affect the usefulness of the joint.

If the exudate is becoming purulent, one is never in any doubt. There is temperature, and especially pain; the skin over the knee becomes glossy, red, hard to pick up between the finger and thumb; there may even be lymphangitis or enlarged glands. If there is any doubt, one may aspirate fluid for examination. But it is as well not to be in a hurry. Once the synovia has given up the fight, the problem becomes a different one.

Infection having once established itself, a stiff joint is the best result to be expected. One need not, therefore, be afraid of making large incisions into it. I open into the joint above the patella, pass a curved director down laterally each side, and make a big slit on to the point of it as far back in the joint as possible. In each of these directions a tube is passed. If the supra-patella pouch is big, a third tube is passed upwards, the ends of all three coming out together at the median opening. The wounds are then dressed daily with saline gauze and a few drops allowed to run down the tubes to keep the lumen clear; beyond this nothing is done. I feel very strongly against continuous irrigation, syringing, or any attempt to wash out the joint. In a cavity of such a complex shape as the knee-joint one cannot expect to get a flow through of solution; the chief result is to set up eddies which wash infection into places from which it has been, perhaps, hitherto shut off, and to start tracks along muscle planes. It is much safer to ensure that such flow as there is, is in an outward direction. This is attained by complete rest and free openings. A small point, but important, is that tubes should be slit longitudinally and not holed. When holes are cut, in a week a little button of granulation has grown through each, firmly anchoring it to the walls of the track, where it is rigidly fixed, blocking rather than assisting drainage; a slit tube always fits loosely and drains well.

If treated this way, in the majority of cases infection will be well under control in a fortnight or three weeks, when the tubes can be pulled out and the tracks allowed to granulate.

I have only tried wide opening of the joint once as a last resort before amputating, so that it was not a fair trial. I have seen it tried frequently, rarely with success. The large area exposed makes the dressings extremely wearing to the patient, and in the ones I have seen, amputation nearly always followed. As the above methods have only twice failed me, I feel the larger procedure is hardly justified.

As to primary excision, I have heard a good many French surgeons recommend it—none with much conviction—and one junior man at a big hospital of 1,000 beds condemns it from his observations with considerable conviction. It seems wrong in principle gratuitously to open up cancellous tissue during a stage of acute infection, especially when more conservative methods are so satisfactory.

Results.—Excluding the five cases mentioned in Class E, and several cases which did well, but in which actual penetration of the joint was not certain, I have before me notes on 50 consecutive cases of wounds of the knee-joint.

The result of these on discharge were as follows:—

Clean moveable joints	29
Clean joints with limited mobility	6
Stiff limbs	12
Amputations	2
Deaths	1

I will deal with the last two first.

The one death (Case 46) was totally unconnected with the injury to the knee. A shrapnel bullet had split off the internal condyle, and was

lying in the space between it and the rest of the bone. It was removed. The patient died eight days later after an acute attack of dysentery lasting three days, during which he passed continuous watery stools. Post-mortem, the joint was absolutely clean.

Of the two amputations, in one (Case 47) besides a bit of shell entering the joint at the outer side and chipping the external condyle and head of the tibia, there were multiple wounds of the calf and thigh, and an acute cellulitis of the whole limb. Hot compresses were applied from thigh to ankle for a week, making real immobilisation impossible. The other (Case 43) had multiple small wounds of the limbs, including two very small ones above the right patella. X-ray examination was negative. I did not recognize any infection of the joint till fifteen days later, when I opened up the track and got out little bits of mud and stone. Infection appeared limited to the supra-patella pouch. Eight days later, however, I had to drain the joint, and after eight weeks amputated through the thigh. Had I recognised the presence of foreign bodies in the joint at once, his limb might have been saved. Looking at the cases from the point of view of the classification given above, there are in :—

Class A—10 cases.

Results.—Complete mobility	...	6
Partial mobility	...	1
Stiff knee ...	...	2
Amputation ...	...	1

Class B—7 cases.

Results.—Complete mobility	...	2
Partial mobility	...	2
Stiff knee ...	...	3

Class C—18 cases.

Results.—Complete mobility	...	15
Partial mobility	...	1
Stiff knee ...	...	2

Class D—15 cases.

Results.—Complete mobility	...	6
Partial mobility	...	2
Stiff knee ...	...	5
Amputation ...	...	1
Death	...	1

Summary of Cases Quoted.

1. S. Piece of shell entered behind, localised in outer side of left knee joint. No fracture. Extracted on X-ray table. Went out healed, with moveable knee.

2. G. Fragment of shell removed from outer aspect of left knee joint. Not drained. Did well; moveable knee.

3. J. Ragged wound across joint above patella. Joint washed out with peroxide; immobilised. Saline compresses. Clean result; freely moveable knee.

4. C. Through and through wound of right knee-joint with fracture of patella; joint washed out with peroxide. Left with clean healed wound and painless moveable knee.

5. Le M. Shell wound above patella. Bit of shell removed from under upper border of patella; not drained. Suppuration later, with a track down calf. Drainage. Wounds much cleaner when evacuated.

6. B. Penetrating wound without fracture. First case done by technique described. Large bit of shell removed from joint just below upper border of patella. Aseptic result with free movement, in spite of great trouble in persuading patient, who was half witted, to keep still.

7. M. Penetrating wound without fracture. Bit of shell entered below patella and lodged near crucial ligaments. Removed by usual routine. Aseptic result with free movement.

8. D. Open wound of knee with fracture; lower half of patella shot away. Main joint cavity remained uninfected. Probable result, stiff knee.

9. C. Two bits of shell penetrating right knee-joint. X-rays showed them lying outside the joint. Not extracted, as they gave no trouble. Clean, moveable knee.

10. C. Open wound of knee-joint. Fracture of patella, and (incomplete) of both condyles. Saline dressings. Infection remained limited to wound. Clean, but stiff knee when discharged.

11. V. Penetrating wound of right knee. Patella smashed, and ragged wound of external condyle. No foreign body. Packed with saline gauze. Healed practically cleanly. No obvious infection of rest of joint; movement, however, not likely.

12. P. Open wound of left knee-joint (no details in notes). No fracture. Drainage. Did very well, wounds being clean on discharge; stiff knee.

13. L. Fragment extracted from right knee-joint. Pus in joint. Washed out with saline, sewn up, and ether injected. Did very well. Should get movement. (Evacuated at end of three weeks.)

14. C. Through and through wound of outer side of right knee-joint, with fracture of patella. Numerous bits of bone removed, but joint not drained. Kept quite clean till one day he was sent out on a stretcher, and infection of whole joint supervened. Joint drained. Slow septic course. Finally, after three and a half months was sent out with wounds nearly healed and a stiff knee.

15. G. Inter alia, a bit of bomb entered right knee joint from inner side, crossed it (? bony injury), and lodged in external lateral ligament. Extracted; no drainage. Perfect result with free movement.

16. P. Small bit of shell had penetrated right knee; X-rays showed it lying in quadriceps tendon. Not touched. Clean, moveable knee on discharge.

17. E. Shrapnel bullet entered right knee just in front of biceps tendon, passed across back of joint, splintering articular surface of both condyles, and emerged through capsule, being shown by X-rays just to the inner side of it. Bullet and loose bits of bone and cartilage were removed, and tube put down to capsule for 48 hours. Healed without obvious infection. Should get some movement.

18. B. Messy wound through and through above patella. Bridge of skin cut across with scissors; saline dressings. Purulent fluid expressed from subcrureal pouch. Later drainage tube put in (subcrureal pouch only). Did well. Will probably get some movement, main joint cavity not being infected.

19. M. Penetrating wound of upper part of right knee-joint. Operation 36 hours after injury. Piece of shell localised in supra-patellar pouch. Track dissected out; gush of pus from joint. Projectile and cloth removed; joint washed out, and small tube put down along track. Four days later joint had to be opened and drained. Cleaned up slowly, after abscess in calf. Wounds nearly healed on discharge. Stiff, useful knee.

20. P. Shell wound over centre of patella; shell localised in popliteal space behind internal condyle. Removed, with many splinters of internal condyle. Patellar wound also dissected out and loose bits of patella removed. Joint contained blood only. Washed out; both wounds closed, and ether injected. Did extremely well; had about 45 degrees movement on discharge after three weeks.

21. D. Shell wound of left knee. Bit of shell localised in centre of internal condyle. Immobilised only; fluid absorbed and wound healed. Discharged with good movement. Projectile extracted aseptically in Paris two months later.

22. B. Shrapnel wound of right knee above patella. Bullet lodged between condyles close to spine of tibia; slight backward displacement of tibia (? injury to crucial ligaments). Joint entered by vertical incision below and to inner side of patella; bullet removed; bloodstained fluid only found. Aseptic result with free movement (? how good, owing to injury to ligaments).

23. M. Dirty shell wound of right knee; no fracture or foreign body. Immobilisation and compresses; not drained. Cleaned up well. Good movement.

24. K. Large open wound of front of right thigh, with gas infection; escape of synovial fluid above patella. Joint not drained. Sealed off without infection.

25. F. Wound of left popliteal space. Two fair sized bits of shell localised behind external condyle. Removed, along with two loose bits of articular cartilage. Joint not drained. There was total section of small sciatic, partial section of external popliteal nerves. Clean result. Moveable, uninfected knee.

26. C. Bit of shell in right thigh, three bits in right knee-joint, one above patella, one behind patella which was smashed badly, one deep to patellar tendon. All removed; articular surface of femur found scored; wounds excised, with large amount of patella. Two days later gas infection of thigh; muscles split up, and knee, owing to proximity, re-opened and drained, but it was remarkable that this was clean in spite of infection of thigh. Cleaned up slowly; discharged after nine weeks, with wounds nearly healed.

27. G. Penetrating wound of right knee. Large bit of shell, over one inch by half an inch, embedded in front of femur. It had entered above the patella, and was lying behind an upturned flap of bone and cartilage, with some pus round it. Removed by incision to inner side of patella. Two days later gas infection of wound. Joint opened and drained. Cleaned up slowly. Discharged in six weeks with wounds very clean.

28. L. Multiple shell wounds both legs, about half a dozen over left knee-joint. Stellar fracture of patella. Two bits of shell removed, blood washed out, and patella stitched with stout catgut. Two days later gas in tissues, calf tense. Calf split both sides; stitches removed from knee and small tube put across under patella. Cleaned up well after this; infection remained localised to front of joint; discharged in five weeks with clean, granulating wounds.

29. R. Entry wound middle of thigh, exit lower part of calf; track 18 inches long. Fluid in knee, slightly bloodstained. Immobilised only. Cloth came out of upper wound; fluid subsided; freely moveable knee on discharge after 15 days.

30. D. Inter alia, two bits of shell penetrated right knee-joint. One localised in peri-articular tissues, one bedded in external condyle. Removed; the bit in the condyle was in a foul infected cavity. No closing done; tube put through joint immediately. Did very well; discharged after five weeks with wounds clean.

31. G. Penetrating wound of popliteal space. Small bit of shell localised between condyles behind. Fluid in knee. Immobilised only. Fluid cleared up.

32. Q. Multiple shell wounds of both thighs, chest, and right arm and hand. Three fragments localised in right knee-joint. Removed; pus in joint, and smashing of articular surface of tibia and internal condyle; loose bits of bone removed; tubes put through joint at first operation. Further incisions one week and three weeks later. Cleared up slowly. Wounds in good condition on discharge after six weeks.

33. D. Bomb wound inner surface of left knee. Fluid in joint. Fragment had traversed supra-patellar pouch and was localised in in-

ternal condyle. Not extracted. Immobilised. Left with moveable knee; temperature normal.

34. G. Very large tearing shell wound in lower part of right thigh; gas gangrene; opening joint above patella. Extensive cleaning up; whole cauterised with pure carbolic; small gauze plug left in hole in joint. Did very well; knee joint never infected.

35. V. Very large superficial wound of left thigh opening into knee-joint at its outer side; mild infection; five days later a tube put into joint and kept there 14 days. Infection rapidly overcome. Stiff knee. This patient also had infected smash of left wrist joint, a metastatic infection of right hip and left ankle joints.

36. J. Small bit of shell penetrating right knee. Localised at outer side. Immobilised; not extracted. Fluid subsided. Evacuated fifth day.

37. B. Wound inner side of right knee. One bit of shell embedded in internal condyle, another free in joint. On dissecting out track, flow of synovial fluid brought out the small bit; hole in capsule split backwards, a bit removed with gouge from hole in internal condyle; saline gauze plug put into hole. Aseptic course; should get a good moveable knee.

38. M. Shrapnel bullet entered above patella, passed along outer side of joint, and lodged under external lateral ligament. Bullet removed. Joint washed out, but not drained. Sepsis of a mild type, never needing a tube in the joint. Hard mass formed in the popliteal space. ? Was there a crack of condyle, leading to callus formation. Exploratory incision showed no pus. Went out after seven weeks with wounds healed. Probably stiff knee; possibly a little movement.

39. M. Through and through wound outer side left knee, very ragged and dirty. Two very small bits behind condyle. Two wounds were joined up; foul, sloughing track exposed, with one inch tear in capsule showing external condyle; there was no track going towards bits of shell (?were they from former wound in this leg). Small incision made into supra-patellar pouch, through which joint was well irrigated. Wound well trimmed up, and tube put through from new incision to wound. Tube removed after three days. Excellent progress with no general infection of joint. Should get fair movement.

40. L. Open wound of patella by shell, with fracture. No foreign body. Saline dressings. Cleaned up extremely well. No general infection of joint.

41. F. Inter alia, wound of right popliteal space. Two bits of shell localised at back of external condyle. Wound in popliteal space was found to lead to a tear in the posterior part of capsule, exposing articular surface of external condyle. Bits of shell not obvious, and, therefore, left. Track cleaned, and tube put down as far as hole in capsule. Tube out in four days. Discharged in 14 days. Wound quite clean; prospect of fair movement.

42. G. One bit in left knee. Entered supra-patellar pouch, lodged in internal condyle near surface. Small amount of fluid in joint. Operated on for other wounds—knee not touched, but immobilised. Fluid absorbed completely; moveable knee on discharge after ten days. Will probably need extraction aseptically later.

43. G. *Multiple wounds; small track* containing stones and mud traversing supra-patellar pouch. Not recognised as penetrating. X-rays negative. After 16 days track opened, and tube put in. Eight days later main joint drained; further incisions after four and seven weeks. Amputation through thigh after eight weeks. Did very well afterwards.

44. C. Wound outer side of patellar tendon. Bit of shell localised exactly in front of spine of tibia, between condyles. Track excised. Shell, wrapped in cloth, luckily extracted with artery forceps without further opening; joint washed and ether injected as usual. Trouble with

pain and swelling of groin. Aspiration of knee showed clear serous fluid. Swelling explained by X-ray plate showing another small bit of shell close to acetabulum. Swelling subsided without operation. Knee aseptic result; should have good movement.

45. B. Wound over patella. Fragment of shell in joint, just below lower edge of patella. Removed by typical technique; some chipping of lower end of patella. Absolutely clean result. Sent out after 13 days with freely moveable knee.

46. R. Shrapnel bullet entered right knee from outer side of popliteal space. X-ray showed separation of internal condyle, with shrapnel bullet oldged in the fissure. Bullet removed by incision to inner side of patella. Died eight days later from acute dysentery. Post-mortem, knee found very clean.

47. V. Multiple wounds both legs. Regular streptococcal cellulitis left leg. Large bit of shell in left knee joint, embedded in articular surface of femur. Bit removed. Knee-joint full of pus, therefore tubes put in at once. Further incisions for tracking after 17 days, three weeks, seven weeks, and eight weeks. After ten weeks patellar tendon cut across, joint widely opened and put up in acute flexion. One week later, amputation through the thigh. Did very well afterwards.

48. H. Bit of shell at upper end of suprapatellar pouch. Removed; joint not washed out. Next day fluid in joint and temperature 100·2°; after this normal temperature. Splint removed ninth day. Movements perfect.

49. H. Distorted German bullet entered inner side of head of left tibia in an upward direction. Lodged back foremost at outer side of bone, projecting into joint. Removed through external incision. Track cleaned as much as possible. Ether injected into joint, also along the track. Cleaned up well, infection limited to outer end of track. Probably a stiff knee.

50. B. Bullet wound through right knee-joint. Entry lower part of internal condyle, exit close to head of fibula. Fluid in joint. Dressed and immobilised. Tenth day splint taken off and movements begun. Full range of movements obtained.

Cases in Class E Omitted.

1. G. Wound through and through of left thigh; much comminution of lower part of shaft of femur, and both condyles; comminuted fracture of left tibia with one inch loss of substance; compound fracture of right tarsus; large tearing wound of right thigh. The knee had been opened at a clearing hospital. Discharged about two months later with all wounds in very good condition.

2. C. Open wound of left knee. Patella smashed, lower end of femur for about six inches broken to bits, fragments of condyle lying loose among the muscles, and one large bit of shell among the bone. Amputated after one week. Pyæmic infection. Ultimately did well.

3. C. Infected wound through upper end of left tibia, with extreme comminution of head of bone, and infection of left knee; small penetrating wound of right knee with infection of joint. Discharged after drainage three months later with two stiff knees.

4. R. de R. Smash of whole lower end of femur involving both condyles; extreme comminution. Gas infection up to groin. Infection too high for amputation. Therefore, thigh split widely open, patella turned back, and a large amount of bone debris removed. Died after four days.

5. —. Wound of thigh from side to side just above knee. Lower end of femur, including both condyles, pulverised; no solid bone till well above condyles, and shaft of femur driven down into fractured mass. Nevertheless did well. Wounds clean, and general condition very good on discharge. W. H. O.

For Photographs see Supplement.

GUY'S HOSPITAL ROLL OF WAR SERVICE.

1.—Medical School and Staff (Past and Present).

Additions and Corrections to the First List.

Allen, N.			Artists' Rifles.
Andrews, J. A. ...	Temp. Capt.	...	R.A.M.C. (Mentioned in despatches. Wounded.)
Andrews, R. C. ...			Artists' Rifles
Bevan, A. H.			R.A.M.C., 23rd F.A.
Bird, T.			Anæsthetist, London County War Hosp.
Black, G.	Major ...		...R.A.M.C. (T.F.), I/c. Military Hospital, Khartoum.
Boland, E. R.			London Rifle Brigade.
Bolus, P. R.	Capt. ...		...R.A.M.C., 25th F.A., 8th Division.
Cocking, A. W. ...	Surg.-Prob.		...R.N.V.R.
Cole, Percival P. ...			Hon. Surg., King George's Hosp.; Operating Surg., Brook War Hosp.
Copley, Stanley ...	Capt. ...		...S.A.M.C.
Cross, F. G.	Temp. Capt.	...	R.A.M.C. (In India.)
Crump, C. Harold ...	Capt. ...		...New Zealand M.C.
Darke, S. J.	Temp. Lieut.	...	R.A.M.C. (Wounded.)
Davies, G.			Artists' Rifles.
Davies, H. A. B. ...	Temp. Capt.	...	R.A.M.C.
Davis, H. H.	Temp. Capt.	...	R.A.M.C. (Mentioned in despatches. Salonika.)
Dean, A. C.	Temp. Lieut.	...	R.A.M.C. (Dental).
Dennett, F. J. T. ...			Surrey Yeomanry.
Dimock, E. C. ...	Temp. Lieut.	...	R.A.M.C. (Dental).
Dingley, W.			Universities and Public Schools Batt.
Doherty, J. N. ...	Temp. Lieut.	...	R.A.M.C. (Dental).
Dunning, J. B. ...	Temp. Lieut.	...	R.A.M.C. (Wounded.)
Eastes, G. L.	Capt. ...		...R.A.M.C. (T.F.), 2nd Lon. San. Co. (Mentioned in despatches.)
Eddison, H. W. ...	Surg.-Prob.		...R.N.V.R.
Edney, C. H.			Ho[illegible]. Artillery Company.
Eglington, D. C. ...			Artists' Rifles.
Elkington, G. W. ...	Lance-Corpl.		...Artists' Rifles.
Ellis, G. G.	Temp. Lieut.		...R.A.M.C (Dental).
Ellis, J. S.			India[illegible]osp. Ship "Glengorm Castle."

Fasken, N. E.	Lieut. ...	...Royal Marine Artillery.
FitzGerald, G. H. ...	Surg.-Prob.	...R.N.V.R.
Fox, F. L. H.		Royal Garrison Artillery.
Fripp, Sir A. D., K.C.V.O.		Cons. Surg. to the Admiralty.
Gardiner, J. J. ...		
Garland, J. O. ...	Temp. Lieut.	...R.A.M.C.
Gripper, G. D. ...	Temp. Lieut.	...R.A.M.C. (German East Africa.)
Hall, Maxwell		Artists' Rifles.
Hallett, L. R. J. ...		5th Royal Sussex Regt.
Hardy, E.	Private	...R.A.M.C.
Hart, J. A.	Private	...Artists' Rifles.
Hearn, R. J.	Capt. ...	...R.A.M.C.
Helsham, C. T. ...	Surg.-Prob.	...R.N.V.R.
Herbert, A. S.	Temp. Major	...N.Z.M.C., M.O., King George V. Military Hosp., Rotorua, N.Z.
Humphry, L.	Lieut.-Col.	...R.A.M.C. (Mentioned in despatches. C.M.G.)
Hitchings, D. B. ...	Private	...28th County of London Regt.
Hutchinson, F. E. ...	Capt. ...	...Australian M.C., 8th F.A.
James, B. E.	Temp. Lieut.	...R.A.M.C. (Dental).
Johnson, W.	Capt. ...	...R.A.M.C., 58th F.A. (Military Cross.)
Kidd, W. S.	Temp. Lieut.	...R.A.M.C.
Kinsey-Morgan, A. ...	2nd Lieut.	...R.A.M.C.
Kirkland, G. B. ...	Surg. ...	...L'Hôpital Anglo-Francais, Le Treport.
Lacey, Wm. S. ...	Temp. Lieut.	...R.A.M.C., 140th F.A. (Died of wounds.)
Liebson, A. S. ...	Capt. ...	...R.A.M.C. (Military Cross.)
Mahon, Ed. M. ...		Resident M.O., Endsleigh Palace Hosp. for Officers.
Malleson, H. C. ...		Hon. Cons. Dental Surg. to Hospitals in London.
Margolies, Ivor ...	Serjeant	...13th Yorks.
Martin, A.	Major ...	...N.Z.M.C. (Died of wounds.)
Maxwell, J. E. ...	Sub.-Lieut.	...R.N.V.R., Royal Naval Air Service.
Meares, A. L. D. ...		Govt. Dist. Examiner of Recruits, Sydney, N.S.W.
Miller, F. C. ...		Universities and Public Schools Batt.
Minett, P. F. ...	Staff Surg.	...R.N.
Moore, R. A.		Royal Garrison Artillery.
Morris, O. Gwyn ...	2nd Lieut.	...Welsh Regt.
Munro, D. J.	Temp. Surg.	...R.N.
Muir-Smith, H. ...		Inns of Court O.T.C.
Murphy, Sir Shirley ...	Lieut.-Col.	...R.A.M.C.
Murray, H. S. ...		Royal Field Artillery.
Newland, W. D. ...	Temp. Lieut.	...R.A.M.C.

Oates, J. L.		Universities and Public Schools Batt., Naval Divn.
Palmer, H. J. ...		Artists' Rifles.
Parfitt, F. W. ...	Private	...A.S.C., Motor Transport.
Parry-Jones, O. G. ...	Capt. ...	...R.A.M.C. (S.R.). (Died of wounds.)
Parry-Price, H. ...		
Penfold, W. D. ...		Universities and Public Schools Batt.
Phipps, J. H.	Lieut.-Col.	...A.M.C., O/C 5th Australian F.A.
Pillow, H. M. S. ...		Universities and Public Schools Batt.
Pomeroy, J. M. ...	Temp. Lieut.	...R.A.M.C. (Dental).
Poole, S. K.	Surgeon	...Duchess of Portland's War Hospital, Elmton, Chesterfield.
Pretorius, W. J. ...	Trooper	...King Edward's Horse.
Punch, A. L. ...	Temp. Surg.	...R.N., H.M.S. "Pembroke."
Ray, E. Reynolds ...		Surg. to County of London War Hosp.
Remington, W. ...	Private	...Artists' Rifles.
Richards, L. P. ...	Temp. Lieut.	...R.A.M.C. (Dental).
Saner, F. D.	Temp. Lieut.	...R.A.M.C.
Saunders, S. J. ...	Temp. Lieut.	...R.A.M.C. (Dental).
Shelswell, A. H. ...	Surg.-Prob.	...R.N.V.R.
Shipway, F. E. ...		Hon. Anæsthetist, King George Hosp., etc.
Sowerby, V. H. ...		Artists' Rifles.
Stacey, J. B.	2nd Lieut.	...
Stallman, J. F. H. ...	Temp. Lieut.	...R.A.M.C.
Stiven, F. W.		Royal Fusiliers.
Stokes, D. L.	2nd Lieut.	...9th Royal West Kents.
Symonds, Charters J....	Temp. Col.	...R.A.M.C. (C.B. Mentioned in despatches.)
Symonds, C. P. ...	Capt. ...	...R.A.M.C. (Medaille Militaire as combatant in Retreat from Mons.)
Thomas, A. R. ...	Staff Surg.	...R.N., H.M.S. "Talbot."
Thompson, Robt. ...	Temp. Major	...Australian M.C.
Ticehurst, G. A. ...	Temp. Lieut.	...R.A.M.C., 33rd F.A.
Tidd, G. M.		Inns of Court O.T.C.
Walley, Thos. B. ...	Temp. Capt.	...Australian M.C.
Ward, L. W.	Temp. Lieut.	...R.A.M.C. (Dental).
Warrick, R. W. ...		Dresser, L'Hôpital Anglo-Francais, Treport.
Wearing, D. G. ...	Temp. Lieut.	...R.A.M.C. (Dental)
Wilks, J. H.	Temp. Lieut.	...R.A.M.C.
Williams, C. Hammond	Lieut. ...	...A.S.C.
Young, J. F.	Temp. Capt.	...R.A.M.C.

List of Honours.

C.B.

Symonds, Col. Charters, J., R.A.M.C.

Military Cross.

Johnson, Capt. W., R.A.M.C.

Liebson, Capt. A. S., R.A.M.C.

Medaille Militaire.

Symonds, Capt. C. P., R.A.M.C.

Mentioned in Despatches.

Davis, Temp. Capt. H. H., R.A.M.C.

Eastes, Capt. G. L., R.A.M.C. (T.F.)

Humphry, Lieut.-Col. L., R.A.M.C.

Symonds, Temp. Col. Charters J., C.B., R.A.M.C.

Died.

Lacey, Wm. S., Temp. Lieut., R.A.M.C., 140th F.A.

Martin, A., Major, New Zealand M.C.

Parry-Jones, O.G., Capt., R.A.M.C. (Special Reserve).

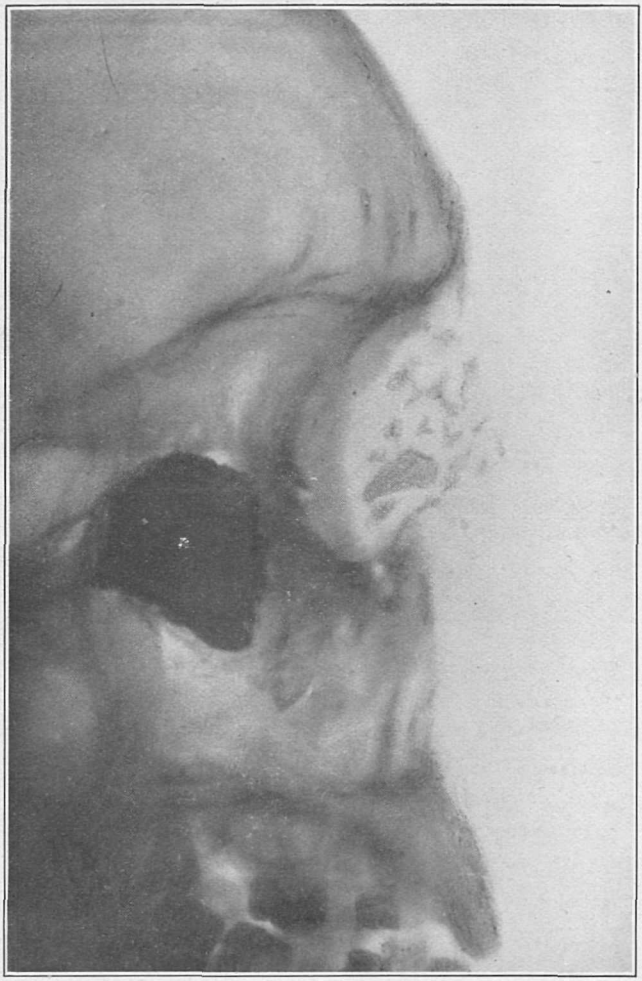
Memorial Services for Members of the University of London who have fallen in the War.

The Memorial Services which were arranged last year in memory of members of the University of London who have fallen in the war will be repeated again this year. One will be at 5.30 p.m. on November 1st (All Saints' Day) in the Temple Church, when the sermon will be preached by the Lord Bishop of London. The Bishop of Kingston-on-Thames and the Chaplain-General, Bishop Taylor Smith, will take part in the service.

Their Majesties the King and Queen, who are Honorary Graduates of the University of London, have intimated that they propose to be represented at this service.

The other service, being a Celebration of Holy Communion in commemoration of those who have fallen, will be on Thursday, November 2nd, at 11 a.m., in the Chapel of King's College, Strand. This latter service is for members of the Church of England only. The celebrant will be the Bishop of Kingston-on-Thames. The musical arrangements at this service will be under the direction of Dr. C. W. Pearce, Director of Studies of Trinity College of Music. Sir Frederick Bridge, King Edward Professor of Music in the University of London, will be present, and will play at the end of the Celebration of Holy Communion.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the Gazette *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*



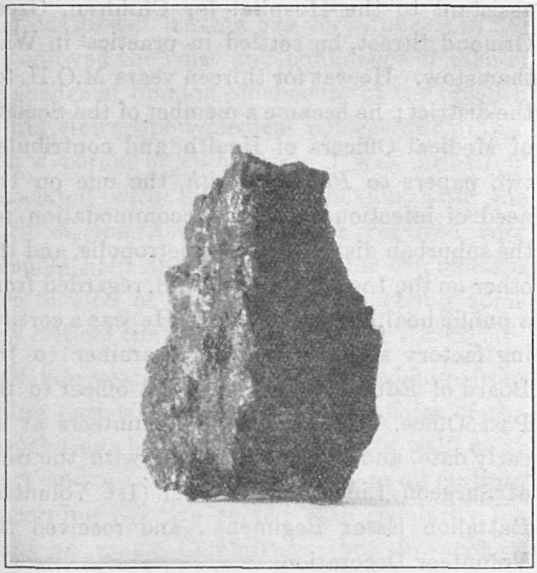
Lateral X-Ray View of Face, showing position and size of the piece of Shrapnel.

[*See Article on page 377*

Case of an unusually large bit of Shell removed from the Right Orbit.

The following case is perhaps interesting, as an example of comparatively small damage caused by a projectile of considerable size:—

Odile Brisneine, private of the 274th infantry regiment, was hit in the region of the left eye by a fragment of shell, during a French attack in the neighbourhood of Douaumont on the 22nd May, 1916. Though he fell to the ground, he was not stunned; he could not see



out of either eye, but his comrades who picked him up told him that his nose was bleeding profusely.

He was admitted under me on May 27th. He did not complain of much pain, and on a first examination his appearance was not very unusual. The right eye was closed. On separating the lids it was obvious that the anterior chamber was full of blood. There was no reaction of the pupil, and vision was nil, even perception of light being absent; the globe did not, however, appear ruptured. The bridge of the nose was only slightly flattened. At the inner canthus of the left eye was a rectangular wound, the vertical limb tearing the canthus, the horizontal one running some distance along the lower lid. He could open this eye, and could see normally with it.

Two X-ray plates were taken of the head, and revealed a very large bit of shell lying along the floor of the right orbit, and projecting into the right antrum. The lateral view showed extreme comminution of the nasal bones.

Operation 28th May.—I first examined the right eye, and found a large tear of the upper surface of the sclerotic, about one inch long, and running in an antero-posterior direction. The eyeball was enucleated. I now introduced a little finger through the lids, and had no difficulty in defining and clearing the upper surface of the projectile, which was, however, firmly wedged. Passing the little finger of the right hand up the right nostril, I found and

cleared the inner and narrower end of the bit of shell. Then, keeping the little finger of the left hand on the shell in the orbit, I seized the inner end through the nostril with strong forceps and slowly rocked it till it was loose. It was then possible, working from the nostril, gradually to rotate the inner end forwards. It was grasped with powerful forceps, and delivered through the lids. A tube was put through from the orbit to the right nostril, and the orbit loosely packed with strips of gauze in sterile vaseline.

After-progress.—The orbit was syringed twice daily with 5 per cent. saline, the flow coming out freely at the nose. Four days later the patient pulled out the tube, and it was not reinserted. He was discharged to a nose and throat centre on the 10th June. The temperature was then normal. The entry wound was perfectly clean, and the swelling of the right orbit and bridge of the nose was much less. There was a steady but inoffensive discharge from the right nostril.

The accompanying photograph shows the bit of shell extracted in natural size. Its dimensions were: weight 83 grammes, length 4·4 cm., breadth 3·1 cm., depth 2·45 cm.

For X-Ray Photograph, showing position of piece of Shrapnel, see Supplement.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

DEAR SIR,—I was much interested in reading the "Guy's Hospital Roll of War Service" in the GAZETTE to-day how splendidly the old Hospital has done. All Guyites may well be proud of the list. I am sure it will be most interesting to all who read your paper.—Yours faithfully,

St. Leonard's House, York.
October 14th, 1916.

W. H. JALLAND.

Obituary.

ST. CLAIR B. SHADWELL, M.D.

A FORMAL announcement of the death of Dr. St. Clair Shadwell, Walthamstow, at the age of 64, was published last week. It occurred at his residence in Walthamstow on September 23rd. He received his medical education at Guy's Hospital, took the diploma of M.R.C.S. Eng.. in 1875, and that of L.R.C.P. in 1876. He became D.P.H. Eng. in 1891, and graduated M,D. St. And. in 1895. After acting as resident obstetrician at Guy's Hospital, and clinical assistant to the Hospital for Children, Great Ormond Street, he settled in practice in Walthamstow. He was for thireen years M.O.H. for the district; he became a member of the Society of Medical Officers of Health, and contributed two papers to *Public Health*, the one on the need of infectious hospital accommodation for the suburban districts of the metropolis, and the other on the Inebriates Act, 1898, regarded from a public health point of view. He was a certifying factory surgeon, medical examiner to the Board of Education, and medical officer to the Post Office. He joined the Volunteers at an early date, and eventually retired with the rank of Surgeon Lieutenant-Colonel (1st Volunteer Battalion Essex Regiment), and received the Volunteer Decoration.

Dr. Shadwell was a member of the British Medical Association, and took a very active interest in its work, especially in matters concerning the Metropolitan Counties Branch. He was one of the small body of men, including Dr. Brickwell of Chigwell and Dr. Percy Warner of Woodford Green, both of whom have predeceased him, who kept the Division together through good and bad fortune. He was one of its early chairmen, an office in which he showed unfailing courtesy and tact. He was Representative of the Division in 1907, 1908, and again

during the controversy as to the Insurance Act in 1910, 1911, and 1912. During those anxious times he expressed the views of his Division in a manner very satisfactory to it. Dr. Pottinger Eldred, an ex-secretary of the Division, to whom we are indebted for some of these particulars, writes:

"The strongest feature in his relation to the Association was his great loyalty to it, and when men consulted him with regard to joining other similar associations his answer was invariably that 'he would not do so; as for himself, he would sink or swim with the Association.' The assistance he gave to the local Division at all times was of the utmost value. His death will leave a gap very difficult to fill. He enjoyed the trust and confidence of men of all shades of opinion on account of the breadth of his views upon medical politics and ethics. For a period of eight years I was intimately associated with him in connexion with the work of the Association, and received very valuable help and suggestions for the efficient performance of my own duties during some very critical times.

Of late years his health prevented him from taking part so vigorously in the affairs of the Association, but he always had its welfare at heart and was deeply interested in all matters concerning it. He served with regularity for years on many Committees, but in such a modest and retiring manner that few men were aware of the great services he rendered. He faced his last illness with a calm courage, knowing that it was only a question of 'how long,' which was the admiration of those who had the privilege of seeing him shortly before the end, and an example to all."

He was a member of the council of the Metropolitan Counties Branch for a good many years, and was at one time chairman of its Ethical Committee. He was also for a short time a member of the Central Council.

A Landsman with the Fleet.

IV.—LIFE'S AMENITIES.

The living instruments of sea power are a people apart, little known to landsmen, who find their ways incomprehensible.—Mahan.

"It baffles me," said the Sub., looking up from his game of patience, "How anyone can be a doctor."

For a moment I did not reply. Indeed, whatever answer I might have made was forestalled by the spirited action of my chair, which slid rapidly across the wet and slippery wardroom floor, depositing us (itself, myself, and Adami's Pathology) in the box of gramophone records.

"It must want a lot of nerve," he continued, turning up an ace and putting the king up, "to have to cut up dead people, and look at all those dreadful —" a heavy sea, dashing against a leaky scuttle, cast aspersions on his remarks. "Anyway, I think of all rotten lives, a doctor's must be the shrieking limit," he concluded, wiping himself dry with a handkerchief.

"Oh no! it isn't," I said, deftly checking the homicidal tendencies of a bottle of anchovy sauce. "At least, on land its alright."

"Meaning, I suppose, that the naval sawbones has a pretty poor show. But he doesn't get roused in the middle of the night to see some old trout who's overeaten herself."

"Doesn't he!" I said, with some bitterness, recalling the last occasion we shipped a green sea when my servant had forgotten to shut the ventilator. "Of course, mind you, I don't say that it isn't a fat job on a big ship. An hour's work in the morning, and the rest of the day to play golf or think out new cocktails in, a fine cabin, decent meals, a band, and all the comforts of a good hotel, but in destroyers, no thanks."

"Well," said the Sub., "a big ship may be alright for you fellows, but I know I wouldn't be out of destroyers for anything. You won't find one destroyer officer out of a hundred who wants to change back."

"There," I replied, "you see, is precisely what baffles me, or any other shore loafer about your job. Going out all weathers to look for some old submarine that isn't there, getting wet through every time you go up on deck, living on iron rations,* and boiled rice for days at a time, never quite getting over the feeling you're going to be violently ill in about five minutes."

"In fact, we're some heroes, what!"

"*Chacun à son metier*, I suppose."

"What does that mean; my Russian's a bit rusty?"

"Well, pretty freely, that you've got to be in a job before you realise that it isn't so bad as it seems from the outside."

"Oh, curse this ruddy sea!" he exclaimed, somewhat irrelevantly, and proceeded to pick up the patience cards which had retreated *en masse* to the floor. "I believe I should have got that one out. Give me four to one I get out the next one."

"I won't," I said, with decision, "I've seen you playing patience before."

After that our conversation was of a purely personal nature.

. . . . .

Though the radical changes in many branches of naval training and education in the last few years, the increasingly democratic tendency observable in the relations between officers and men, and the final removal from the naval curriculum of that branch of seamanship sometimes referred to as "sticks and strings," *i.e.*, spars and ropes, have resulted in the disappearance of the old-time officer, beloved of fiction, yet Admiral Mahan's dictum is no less true to-day than it was of the period of which it was written. Studiously avoiding all "shop" talk when ashore, proclaiming, often enough, a hatred of the sea and all appertaining thereto—the ideal of many N.O.'s appears to be a small farm where they could devote themselves to chicken rearing or early vegetables—the sailor's self-depreciation might be mistaken for inefficiency by those who knew him but casually. It is a reticence which has deeper roots than modesty. It is the silence of men who speak but little of their nearest ideals because they lie so close to the springs of life itself. A lad embarks upon the career of the sea young. From the moment he enters Osborne, he falls under the spell of a potent tradition. The term in which, according to the date of his entry, he is placed, receives its name from that of some great commander or in commemoration of a victory by sea. St. Vincent, Drake, Hawke, Blake, Grenville, under names such as these he spends two years, the most vital, perhaps, of all his life, and in after time he greets men of his own term with the same intimacy as the public school man a fellow-member of his house, or the 'Varsity graduate another of the same year and college. Thence to Dartmouth, where his first introduction is made to the actualities of seamanship, the bending of ropes and sails, the handling of oar and tiller, the scientific way of slinging a hammock, scrubbing a deck, or arranging wash clothes in perfect symmetry. It is a training almost Squeersian in its combination of theory and practice. Here, too, he is initiated into the mysteries of his craft, to sights, stellar and solar, the subtleties of great crick sailing and magnetic variation, to compasses and their adjustment; nor is the mechanical side neglected, and he learns, albeit with a wind duly tempered, of steam, and turbines, and sees with bewilderment the long grey form

* Bully beef.

and whizzing vitals of the "mouldy,"* to direct which with deadly effect will form so much of his life's work. Then, too, there is gunnery, a dry and abstruse subject, full of technicalities, muzzle velocities, trajectories, explosion values, which one day when he reaches Whale Island will suddenly assume a real and positive meaning. At last he passes out and tastes for the first time the fruit of this long maturing, for now a fully fledged cadet he embarks upon a cruise upon a real man-of-war, hears the hands piped to general quarters in real earnest, salutes officers engaged upon duties more actual than the training of cadets, suffers, perhaps, from sea-sickness, from home-sickness, from the loneliness which is bitterer than all solitude, the loneliness felt in the midst of the crowd. But all this is soon forgotten when the destination is reached, a trip in the Mediterranean, perhaps, or Bermuda, and the West Indies, where kindly ladies organise dances for the cadets—"so young, you know, to be away from home"—where life is one long enchantment of picnics, bathing, camping-out, strange adventures and a strange dietary. Then, for delights such as these cannot last for ever, the return home to pass the exam. which shall convert him from a nonentity to a midshipman "complete with dirk and patches" (*vide* the outfitters' catalogue), a member, however humble, of a gunroom mess, commanding (under the respectful guidance of the coxswain) a picket boat which races everyone else's picket boat till some disaster calls down the commander's wrath and the heavy hand of the senior sub-lieutenant. Space, alas! does not permit me to trace his gradual rise through the gradations of "snottyhood" (no, gentle reader, snotty or wart, if you will, but never "middy"), to a final presidency of the gunroom mess, which doubtless he rules with a rod of iron, and thence in the fulness of time, to a lieutenancy and the privilege of consorting with the Olympians of the wardroom. A pen far abler than mine has described it already in two books which are a mine of information to the student of matters naval, "A Tall Ship" and "Naval Occasions." It is easy, however, to realise by what gradual transitions the Osborne fledgling becomes a living instrument of sea power, one of the most efficient machines, surely, ever devised by the wit of man.

Parallel to this elaborate training of the officer, runs that of the man. Less deliberately didactic perhaps, relying even more upon the value of manual and visual demonstration, the path of the lower deck man from the time he enters the service at fifteen or so as a "Boy, 2nd class" to the time when he retires as Chief Petty Officer, Warrant Officer, or nowadays, a change with which I shall deal in a moment, as Commander R.N., is strewn with examinations.

The ratings are innumerable, to the landsman well-nigh unintelligible. Distinguish, for example, between the various seaman ratings, ordinary, able, leading-seaman, coxswain, boatswain; the stoker ratings, second class, first class, petty-officer, warrant officer, chief warrant officer, warrant mechanician, and remember that every branch of the service, the artificers, the gunners, the torpedo instructors, the signallers, the writers, the telegraphists, the sick berth attendants, the naval police, has graduations as complicated, and you will realize how vast an organization is required to mould all these scattered units to coherence. I doubt whether any one outside naval circles can fully appreciate the revolutionary change effected by Winston Churchill when at the Admiralty in 1912, by introducing the "mate" system. Formerly lower deck and wardroom were two entities as far apart as the poles, and the thought of one merging into the other so monstrous that to have suggested it would have been enough to

*Torpedo.

provoke something very like open rebellion on the part of the latter. Thanks, however, to the genius of Winston, the change has been effected without any lowering of tone in the wardroom or appreciable uppishness on the part of the lower deck. Naturally the greatest care is exercised in selecting candidates for such advancement. From time to time the captain of a big ship is asked to nominate a small number of men—they are in practice generally chosen from among the younger Chief Petty Officers and Warrant Officers, who, in his opinion, would prove suitable candidates for examination. These have then to pass before a special selection board which rejects candidates likely to be unsuitable upon social grounds, and the remainder are sebsequently weeded out by an educational test. Those who are successful are appointed acting mate for a probationary period of about six months, when they are confirmed in rank and thence proceed through the usual stages of promotion—1st Lieutenant after two years, and so on. While it is too early in the day to predict whether men so promoted will ever rise to the highest commands, captain, commodore or admiral, they have repeatedly won their laurels as destroyer officers, where, if anywhere, sterling qualities of seamanship are called for. The change is one that goes to the very root of the popular discontent with both services, the limited prospect of advancement for a lad of intelligence and energy. Before its introduction, the rank of warrant officer was the highest that could be reached (except under the very improbable assumption that a man had been for, I think, twenty years a warrant officer, when he became a 1st Lieutenant) and it was an act of the barest justice to acknowledge, albeit tardily, the faithful and arduous services performed by the warrant ratings.

Like his brother in the army—the old-time N.C.O., he had to prove himself the possessor of no mean intelligence (if you have ever studied the Torpedo Manual, gentle reader, you will know what I mean) capable of commanding men although himself of their own class, an able instructor, deferential, possessed of infinite tact—teaching the elements of gunnery or boatwork to a class of unruly snotties is not always the easiest task—a colossal worker, no mean combination of qualities for a man who has entered the service as a boy and has never seen life save from the limited outlook of the lower deck.

The time may come when yet freer access to commissioned rank is made open to the men of His Majesty's Navy, in the sister service the experiment has been tried with apparently every success. But the peculiar conditions of life at sea render any but the most careful introduction of such a scheme a change fraught with grave dangers. *Esprit de Corps*, though the experience of our boyhood essay writing might incline us to doubt it, can be and is a very real factor in making, in accepted phrase "a happy ship." One uncongenial spirit may wreck the happiness of a wardroom. A mess divided against itself makes for slack discipline, disaffection, all the train of disasters which follow the slightest breach of naval convention. So if sometimes one hears murmurings against official slowness in introducing this or that reform, it must be remembered that the unique conditions make any comparison with shore life impossible. It is easy to preach the equality of man, to live at peace with all men is another matter.

G. H. F. G.

Prizes for Red Cross Needlework.

An especially attractive effort to assist the British Red Cross is to be made at the Central Hall, Westminster, on November 7th, 8th, 9th and 10th.

The Marchioness of Ripon opens on the first of these days what promises to be the greatest

show of needlework ever held, and everything will be for sale. The enthusiasm with which the scheme has been taken up is largely due to the fact that the *Daily Sketch* is offering £1,000 in prizes. There will be several thousands of competitors.

Attending the stalls will be nearly all the leaders of London Society, and the prettiest actresses will also be there.

There is a special class for wounded soldiers, and it will be something of a revelation to see how cleverly the hands which have manipulated the rifle and bayonet to such good purpose have been able to accomplish the more delicate achievement of needlecraft.

Change of Address.

E. Royston Saul, L.D.S., 17, Harrington Gardens, W.

Lieut. J. Edmond, M.B, R.A.M.C., from No. 11 General Hospital, to 60th Field Ambulance, B.E.F., France.

2nd Lieut. J. H. E. Winston, Headquarters A Group, 3rd Line, Northumbrian Division, Kirkleatham, Yorks.

Allen P. Piggott, M.R.C.S., St. James' Infirmary, Upper Tooting, S.W.

Montagu F. Hopson, L.D.S., Eng., from 64, Harley Street, to 7, Harley Street, W.

Lauriston Shaw, M.D., F.R.C.P., from 64, Harley Street, W. to 12, Park Square West, N.W. (Telephone 1480 Mayfair).

Lieut. R. Curle, R.A.M.C., No. 6 Camp, Codford. Wilts.

Capt. D. Clewer, R.A.M.C., from Dental Officer, Seaford Garrison, Sussex, to Dental Officer, 2/2nd London Casualty Clearing Station, 4th Army, France.

Capt. W. A. Easton, No. 15 General Hospital, Alexandria.

Lieut. L. Muir-Smith, R.A.M.C., from 32nd Field Ambulance, Salonika Army, to 25th Casualty Clearing Station, Salonika Army.

Lieut. N. E. Kendall, R.A.M.C., 245 M.T.Co., A.S.C., Salonika Forces.

F. E. Hutchinson, 8th Field Ambulance, A.I.F. France.

2nd Lieut. V. Drew, 9 Duke of Cornwall's Light Infantry, c/o Messrs. Cox & Co., Bankers, Army Agents, Karachi, India.

G. N. Meachem, M.D., from 11, Devonshire Street, Portland Place to Sherburn House, Durham.

A. F. Salsbury, L.D.S., Birchwood, Sydney Road, Guildford, Surrey.

A Case of Heart Failure during Operation for removal of Tonsils and Adenoids: Heart Massage through an Abdominal Incision: Recovery.

Report by H. STERNE HOWITT and G. E. L. SYMONS.

Albert D., æt. 6, was sent to the Throat Out-Patient Department with a view to having his tonsils and adenoids removed. He was a delicate-looking boy with a previous history of asthma and bronchitis.

The patient was prepared for an anæsthetic in the usual way, and C.E. mixture (two parts chloroform, three parts ether) was given on an open mask. Unconsciousness quickly supervened, the "excitement" stage being absent. Light anæsthesia only was maintained, and the corneal reflex was present.

The left tonsil was removed by the guillotine, and as the right one was being negotiated, the child moved his head and struggled slightly. The adenoids were quickly curetted, and cold water was then poured over the face. It was noticed the child did not struggle while this was being done. As the patient's face was rather cyanosed, a finger was passed into the naso-pharynx, but no blood clot or other cause of obstruction could be found. It was now realised that the breathing had stopped altogether, and cyanosis increased. The head was lowered and Sylvester's method of artificial respiration, combined with tongue traction, commenced. The pulse at the wrist could not be felt, and there was complete muscular flaccidity, and the pupils became widely dilated. Oxygen was given, warm bottles applied, and 1 c.c. brandy injected into the forearm. Artificial respiration was continued, and 0·5 c.c. ether injected, but no improvement was noticeable. An injection of 0·5 c.c. pituitrin was now given subcutaneously

and one or two long-drawn inspirations were given. However, the condition of the patient became worse, and even the injection of 0·5 c.c. pituitrin straight into the heart did not improve matters. Twelve minutes had now elapsed since the cessation of respiration.

As a last resort, Mr. Mollison decided to open the abdomen and massage the heart. The skin was cleaned with ether and asepsis preserved as far as possible under the circumstances. A median incision extending from the ensiform cartilage to the umbilicus was made, and the peritoneal cavity opened. The right hand was insinuated between the liver and diaphragm. The heart could be felt through the diaphragm and was massaged vigorously, counter-pressure being applied by the left hand on the chest wall.

As no improvement followed after five (query one to two) minutes, 1 c.c. pituitrin was injected into the heart through the chest wall,and massage was again continued in combination with artificial respiration. An occasional sighing respiration took place and the pupils became smaller. After about 20 more squeezes, suddenly the heart was felt to begin beating, and the respiration now became re-established. At first the radial pulse was not perceptible, and the boy's condition was still extremely feeble.

The abdominal wound was partly stitched up and the patient hurried to the ward.

Notes added by Mr. W. M. Mollison.

Under the influence of warmth and saline infusion, improvement took place. In about an hour's time the boy became restless and the stitches in the abdominal wound gave way. Mr. Hughes kindly operated and sutured the wound afresh.

The boy was a source of great anxiety for several days; he suffered from the effects of the temporary cerebral anæmia; he was unconscious for two days, he was very noisy, screaming for hours on end; he had incontinence of fæces for about a week and of urine for about ten days. Indeed, it was only due to the unremitting care of the House-Surgeon, Mr. S. Wilson, and the Sister and Nurses of Ruth Ward that recovery was completed, and the boy to-day is perfectly well.

There have been several successful cases recorded of heart massage, but this case is, perhaps, unique in that recovery took place after so long a time of cessation of the circulation. As can be imagined, it is extremely difficult to estimate time in emergencies, but it is certain that the heart had stopped at least 13 minutes, and the impression of those present was that this figure should be between 15 and 20 minutes.

Appointments.

R.A.M.C.

F. D. Saner, M.D., F.R.C.S., to be temporary Lieutenant.

Temporary Captain F. R. Featherstone has relinquished his commission.

The following have been appointed Dental Army Surgeons with the rank of temporary Lieutenants:—J. Cameron, A. C. Dean, E. C. Dimock, J. H. Doherty, B. E. James, H. S. Pugh, E. R. Saul, D. G. Wearing.

R.A.M.C. (Territorial).

Wessex Field Ambulance:—Captain H. N. Collier relinquishes his temporary rank on ceasing to command a stationary hospital.

Papers by Guy's Men.

Charles Higgins, F.R.C.S., Eng.: A note on the use of celluloid in plastic surgery.—*The Lancet*, October 7th, 1916.

Percival P. Cole, M.B., F.R.C.S., Eng.: Spinal Anæsthesia, with special reference to the acute abdomen.—*The Lancet*, October 7th.

R. H. Jocelyn Swan, M.S., Lond., F.R.C.S.: An improved bone drill.—*Ibid.*

H. T. Hicks, F.R.C.S.: Retraction of the uterine muscle associated with obstructed labour.—*The B.M.J.*, October 14th, 1916.

Arthur F. Hurst, M.A., M.D., Oxon., F.R.C.P., Lond.: Trench Fever:—A relapsing fever occurring amongst the British troops in France and Salonica.—*The Lancet*, October 14th, 1916.

A. A. Brown, M.B.,: Farm colony for consumptives.—*The Medical Journal of Australia*, August 26th, 1916.

F. A. K.
K. L. B.

GUY'S HOSPITAL GAZETTE.

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Passim.

IT is with feelings of great regret that we must bid farewell to the Residents who completed their appointments at the end of October. Their loss helps to bring home to us how long the war has lasted. The off-going Residents are almost the last who were well established in the wards in happier days before the war. We are now gradually passing to a new generation who have only known the Hospital in war-time.

Mr. F. A. Knott, the Ex-President, held the appointment of Ophthalmic House Surgeon before he became Out-Patient Officer and then Dr. Beddard's House Physician. He has been a most popular President, and as to his qualities as an H.P. we need say no more than that he was extremely popular with his Ward Clerks, whom he was always willing to help and teach. We are glad to be able to announce that he has not severed completely his connection with Guy's, as he is to hold the appointment of Senior Assistant Bacteriologist.

Mr. A. D. Marston, the late Vice-President, was House Surgeon to Sir Alfred Fripp, after doing Junior Charity and R.O., and has had a distinguished career at the Hospital. We are glad to hear that he is to be Obstetric Registrar, a post where his well known gift for teaching will be given full play.

Mr. J. E. Clark, after doing an appointment as Assistant House Surgeon, became O.P.O. and H.P. to Dr. Fawcett. He is now leaving to join the R.A.M.C., where we trust his career will be as successful as it was at the Hospital.

Mr. K. L. Bates has long been a well known and popular figure in the Hospital. He did six months dressing to Sir Arbuthnot Lane, and has been H.S. to Mr. Steward. We hear that he is going for a time as Resident in Queen Mary's Hospital at Southend to relieve Mr. Scott, who has worked there without a holiday since he left Guy's. We wish Mr. Bates every success.

Mr. D. O. Richards, the retiring R.O., was previously House Surgeon to Sir Alfred Fripp. He has sacrificed a well deserved holiday by staying on at the Hospital to complete his appointment, and had to report at Aldershot on the day on which he finished his appointment here.

We welcome four new Residents who, we are sure, will uphold the traditions of their predecessors. Mr. E. S. Bowes and Mr. R. R. Traill are House-Surgeons to Sir Alfred Fripp and Mr. Steward respectively. Mr. T. E. Michlem has been appointed House-Physician to Dr.

Beddard and Mr. L. S. Gathergood to Dr. Fawcett. Mr. Bowes has done previous appointments here as Charity and R.O.

The GAZETTE has sustained a great loss in the departure of Mr. Knott, who has so ably edited it for the last twelve months, assisted during the last three months by Mr. Bates. We can only hope that the high standard to which it has been brought by their untiring exertions will be maintained.

ON October 31st the College was the scene of cheery festivities, when the Off-going Residents entertained the On-coming Residents and some fifty other qualified men and students. The gathering was universally pronounced to have been the most successful of recent times.

After Mr. Knott had proposed the King, Mr. Wilson, in a speech punctuated by extremely prolonged applause, proposed the health of the Residents leaving us on November 1st. The announcement that Mr. Knott and Mr. Marston are taking up posts on the Junior Staff was the signal for still further applause. Mr. Knott then replied, thanking Mr. Wilson on behalf of the Off-going Residents for the kind way in which their health had been drunk. Mr. Marston then rose, and in a witty speech welcomed the new Residents and congratulated Mr. Medlock on his election as President. After Mr. Gathergood had replied, Mr. Bates proposed the toast of the Visitors, coupled with the name of Dr. Ryffel. Dr. Ryffel was, he said, the great support for any house officer when in doubt about a case, and one to whom the humblest among us could always go for advice with the sure knowledge that he would derive from him valuable and useful information. Further, since the war Dr. Ryffel has worked hard to maintain a military spirit among the students in the O.T.C., while at the same time he has not been too hard on those who from pressure of impending examinations have occasionally found themselves unable to attend every drill. Mr. Bates then went on to say that he regretted that Mr. Thompson, who so often had added to the pleasure of such meetings as the present, was unable to be present that night. Hardly, however, were the words spoken when Mr. Thompson himself walked in amid vigorous applause.

Dr. Ryffel then rose and thanked Mr. Bates and the Residents. He was much pleased to think that he was able to be of assistance. Mr. Thompson then told us that he regretted that his arrival had been so late, but that he had been fulfilling what is, after all, a man's first duty, looking after his wife and children. The hearty applause with which he was received showed that the company believed in the old motto, "Better late than never."

A more serious note was struck by Mr. Tanner, who announced that £500 had been raised to endow a cot in memory of one of the most popular of former Residents, "Puppy" Seabrook. Mr. G. D. Eccles then said a few words about the good work that had been done in Mesopotamia by old Guy's men, notably Mr. Davies-Colley and A. Seabrook. Finally, Mr. Genge-Andrews, back from the R.A.M.C. in France, told us that a Guy's man was sure of a welcome and hospitality wherever he went in that country.

The company then adjourned to the Smoking Room where music and merriment prevailed for some time before the party broke up, and the guests retired to bed with the memory of one of the pleasantest evenings they had ever spent.

WE regret to hear that two more Guy's men have lost their lives in their country's service. J. Stanley Palmer, L.D.S. Eng., who was a Dental House-Surgeon two years ago, has been killed while serving as a Second Lieutenant in the Durham Light Infantry. Wilfred Hollands

was killed on October 12th by a shell exploding at his feet. At the outbreak of war he was a dental student, but resigned his appointment and joined the Public Schools Battalion. Later he obtained a commission in the Royal Fusiliers and served in France as bombing officer.

We have already received a few additions to Roll of War Service published in our issue of October 7th. In spite of the very hard work spent on it by many willing helpers there are still, we think, a number of omissions and errors. Among these we notice in the List of Honours the omission of the name of one of our Consulting Surgeons, Mr. Charters Symonds. Once again we apologise to those who have been omitted, and beg that they will send particulars of their service and honours to the Manager at the Gazette Office, so that a supplementary list may be issued later.

Many Guy's men, past and present, will hear with extreme regret that Mr. L. H. B. Evans died in Bright Ward on November 1st after a short illness.

He came up to Guy's from Cambridge in 1912, and after a hard struggle against ill-health was just on the point of qualifying when he died. But few of his contemporaries are still left with us, but his charming character and the pluck with which he stuck to his work in spite of continued ill-health has endeared him to all. His sudden death just when he seemed to be about to reach the goal of qualification, towards which he had struggled so bravely and so long, cast a gloom over the Hospital. He was devoted to the profession he had chosen, and had nature granted him strength of body equal to that of his intellect and character, he might well have risen to be one of the most distinguished of the sons of Guy's. But, alas, it was not to be. His health broke down just when he needed it most. Perhaps had he had less courage and determination and thrown up his work he might have been alive to-day, but his life up here was one long struggle of mind against matter, and full knowing the danger he ran, he would never give in.

Pass List.

Royal Colleges of the Physicians of London and Surgeons of England.

At the Examination held recently the following candidates were successful.

Part IV.—Practical Pharmacy.

A. W. A. Davies; L. H. B. Evans; D. V. Halstead; G. R. Hubbard.

Society of Apothecaries of London.

The following candidates were approved in the undermentioned subjects at a recent Examination:—

Surgery (Sections i. and ii.)—H. St. H. Vertue.

Medicine (Section ii.)—W. Burridge.

The Diploma of the Society was granted to W. Burridge and H. St. H. Vertue, entitling them to practise in Medicine, Surgery and Midwifery.

Royal College of Surgeons of England.

In the list published of successful candidates at the First Professional Examination for Licence in Dental Surgery held recently, we regret that the name of W. W. Truscott was inadvertently omitted.

Change of Address.

Capt. J. L. Percival, R.A.M.C., from No. 7 General Hospital, B.E.F., to 132 Field Ambulance, B.E.F.

Lieut. A. J. McNair, R.A.M.C., Indian Expeditionary Force D, c/o D.D.M.S., Basra, Mesopotamia.

N. Mutch, M.D., M.R.C.P., from Hamilton Lodge, Hanger Hill, Ealing, W., to Lydstep, Sheen Road, Richmond.

Capt. L. Horsley, R.A.M.C., from Boulogne to 11th Field Ambulance, B.E.F.

Maurice Pearson, Mas-y-dere, Pencoed, near Cardiff.

Lieut. Cyril Francis, M.D., B.S., L.R.C.P., M.R.C.S., 20th General Hospital, Camiers, A.P.O.S., 18, B.E.F., France.

Cadet J. A. Bouic, Royal Flying Corps, Officers' Cadet Battalion, Denham Camp, Bucks.

Capt. Donald C. Scott, R.A.M.C., D.R., 1st West Riding Field Ambulance, B.E.F.

I Samuels, L.D.S., Voiture de Stomatologie No. 2, G.B.C. Secteur Postale 21. France.

Obituary.

Capt. OWEN PARRY-JONES. R.A.M.C.

We regret to record that Capt. Owen Parry-Jones, R.A.M.C., elder son of Dr. and Mrs. Parry-Jones, Full Street, Derby, has died in France, from wounds received in the recent fighting.

Owen Gu. Parry-Jones was born at Pinxton, D. byshire, in June, 1887. He was educated first at a Preparatory School at Bournemouth, and then at Sherborne School, where he reached the Sixth Form and was School Prefect, but was, perhaps, more distinguished for his musical gifts and athletics. He was a prominent member of the Rugby XV., won the Steeplechase, and was a Sergeant in the O.T.C. He went up to Oxford with a Choral Scholarship at Magdalen College, became captain of the College XV., and played many times for the University. After taking his B.A. degree he entered Guy's Hospital. He was very specially a Guy's man, his father was here from 1878 to 1885, and his mother was for a short time Sister Cornelius. Known to all his friends as P.J., he was beloved by everyone who met him. In the Rugby XV. he excelled as a forward, physically strong and powerful, he was one of the mainstays of a team that for some years remained undefeated in the Final Cup Ties. He also played for Kent, and was a member of two teams that went to France and Austria respectively. Possessed of a very fine baritone voice, his services for "Ward Concerts" at Christmas time were always most eagerly sought after.

In 1913 he accepted a Commission in the Special Reserve of Officers, and was called up when war broke out, when he was just on the eve of qualifying as a medical man, and was sent to the Lancashire Fusiliers as Second Lieutenant. He served with them at their depôt and at Hull for five months, and then in view of the shortage of doctors he was given a month's leave to try and qualify. This he did, and became M.R.C.S. and L.R.C.P. in January, 1915, and was at once gazetted Lieutenant in the R.A.M.C. and joined a training camp at Eastbourne. Promoted Captain in May, 1915, he went out to France in July, 1915, with the 56th Field Ambulance in the 18th Division. For the last few weeks he had been attached to the 8th Suffolks, and whilst with them he met his death. On September 28th he was standing outside the Advanced Aid Post when he received severe wounds from fragments of a shell. He died the following day, and we are told that he remained bright and cheerful to the end. Thus P.J., in laying down his life so voluntarily for his Country, reflects Honour and Glory on the name he bore, which will ever be remembered by his Hospital—Guy's.

Dr. Parry-Jones has received the letters printed below:—

Dear Dr. Parry-Jones,—I am sorry I have not been able to write before to give you what few details I know about your son.

He was attached to this battalion as medical officer, and I need hardly say his work was always very much appreciated by all ranks throughout the battalion.

It was late in the evening on September 28th, when our attack on Schwaben Redoubt was over, that he was wounded by a shell just outside my Battalion H.Q., which were just east of Thiepval. We got him away as quickly as possible, and he then appeared to be fairly comfortable and very cheery under the circumstances.

His work on September 26th, during our attack on Thiepval, was beyond praise. I have personally seen him on other occasions when he was with the Field Ambulance, notably close to Longueval, on July 19th, and was particularly struck by his gallantry.

The whole battalion mourn him very deeply as a brother officer and as one of the bravest

Captain O. G. PARRY-JONES, R.A.M.C.

Died of Wounds in France, September 1916.

men, and on behalf of this battalion please accept my deepest sympathies.—Believe me, yours truly, G. O. W. HILL.

Suffolk Regiment,
22nd October, 1916.

To Dr. Parry-Jones, Derby.

Dear Sir,—You would have been long before now officially informed of the death of your son, Capt. Parry-Jones.

Capt. Parry-Jones was detached temporarily from this unit to Suffolks of this division. It was while acting M.O. to this regiment during active operations that he received wounds from which he died in a C.C.S. a day or two later. He was wounded in the thigh and right side of the chest just outside the advanced aid post of this Field Ambulance. He, Capt. Fraser, the Chaplain, and Lieut. Nuthall, one of my officers, were together outside the aid post when a shell burst close to them, and he unfortunately was struck by some of the fragments. He was immediately attended to by Lieut. Nuthall and taken to the advance dressing station of this unit, whence he was immediately despatched by motor ambulance to the main dressing station.

Unfortunately enough I happened to be out and did not see him, but my adjutant, Capt. McCullum, was present, and he considered his condition good at that time. He was quite conscious and stated he felt much easier than when he got hit. He complained of no pain.

From his condition at that time we felt very hopeful, and the news of his death later on, in spite of the fact that his wounds were undoubtedly serious, came to us as a great shock. Even now we hardly realize that P.-J., as we all called him, is gone. We all feel his death most keenly.

I personally, as his commanding officer, cannot put in words my appreciation and admiration for the excellent qualities shown throughout the campaign by your son. His coolness under fire and fine example to the men under him marked him as an officer who showed utter disregard for his personal safety while work had to be done in the advanced area. He was third senior in this unit, and I feel that this grievous loss the unit has sustained is irreparable.

It is, however, on you, sir, and on your family that this blow falls heaviest. I tender to you all my sincerest sympathy. All the rest of the officers join me in extending to you all our very sincerest sympathy on this grievous loss that you have sustained.

Please accept my apologies for being so long in writing you. But I hope you will understand the difficulties we have to contend with at times, and our circumstances were especially so for the last five weeks. Unfortunately I cannot give you any definite information regarding names of places, etc., just now.—With kindest regards and deep sympathy, I am, yours respectfully,

H. D. MURCHISON,
Major R.A.M.C.,
O.C. 56th Field Ambulance,
B.E.F.

France,
21st October, 1916.

Canon Westcott, his old Headmaster, writes—

Dear Dr. Parry-Jones,—You will let me send you one word of deep sympathy on the death of your gallant son. One does not like to say "loss" in such a case; though it must be for you (I know) the clouding over of a great hope. How well can I remember him at Sherborne singing "Land of Hope and Glory." We didn't think then that he would be called upon, with so many of our best, to lay down his young life in the service of the Country. That he did nobly at the Front, I am very certain, and there is comfort in it, is there not?—Believe me, yours very sincerely. F. B. WESTCOTT.

The Close, Norwich,
October, 1916.

CHAUNCY PUZEY, F.R.C.S.

Consulting Surgeon, Northern Hospital, Liverpool.

It is with regret we have to record the death of Mr. Chauncy Puzey, which took place somewhat suddenly on October 10th at West Kirby, where he had been residing during the few months since his retirement from practice.

As surgeon to the Liverpool Northern Hospital from 1875 down to his retirement from the staff a few years ago, he attained considerable eminence in surgery. He was born in London. His father was head cashier to the Bank of England, and the name Puzey appeared on the banknotes of that period. He received his general education at the Merchant Taylors School in London, and studied medicine at Guy's Hospital. He took the Diploma of M.R.C.S. in 1863, and those of L.R.C.P. Lond. and L.S.A. in the following year. Thirty years later, for his acknowledged reputation as a surgeon, and while he filled the office of president of the Liverpool Medical Institution, he was elected a Fellow of the Royal College of Surgeons of England, an honour which all his surgical friends regarded as most worthily bestowed. In 1865 he was appointed house-surgeon to the Liverpool Royal Infirmary, and during his occupancy of that office was in a position to watch the development of and to carry into practice the Listerian method. Mr. Puzey in the two addresses he delivered as president of the Liverpool Medical Institution gave his hearers an admirable and lucid survey of the earlier period of the Listerian method. He foretold in 1894 that the aseptic animal ligature would hold its ground the longest of the various improvements in the details of surgical practice immemorably associated with Lister. At the time of Mr. Puzey's house-surgeoncy secondary hæmorrhage was the dread of surgeons, and he was able to see this dread abolished by the introduction of the "animal ligature." These addresses of Mr. Chauncy Puzey revealed not only his judgment as a sound surgeon but also displayed his ability to record impartially the struggles through which the new method advocated by Lister had to go before acceptance by surgeons. As a Guy's man he had been taught to rely upon torsion as the most effective measure for arresting hæmorrhage, and realized in his own practice the superiority of the "antiseptic animal ligature" introduced by Lister in 1869.

Mr. Puzey made several contributions to the medical journals, and especially to the *Liverpool Medico-Chirurgical Journal*, dealing with various surgical diseases. These were all of a practical natnre and typical of the author's trend of mind. He was not. nor would he have laid claim to be so regarded, a brilliant surgeon. Mr. Puzey's surgical opinion was sound, well weighed, and only determined after mature consideration. For many years he held the post of medical referee to the London and North Western Railway, and not infrequently appeared as medical witness in cases of railway injury. It was in such circumstances that Mr. Chauncy Puzey showed his surgical judgement and testified with singular clarity of vision and precision of statement.

As a man he was of a retiring disposition and made no use of the little graces that assist men in practice. He was a staunch colleague, considerate, and deeply interested in the hospital where his life's work was done. On retiring from the active staff he was made honorary consulting surgeon and a member of the committee of the hospital. This latter appointment was evidence of the high estimate placed upon his judgement by the hospital authorities and of their anxiety to retain his services.

The funeral at West Kirby parish church was attended by many of his colleagues and friends and representatives of public institutions.

His old schoolfellow and lifelong friend, the Rev. J. Bell-Cox, of Liverpool, took part in the service. Mr. Chauncy Puzey never married, but he leaves behind many sorrowing friends and a fragrant memory of a man who nobly and unostentatiously did his work, and in this it can truly be said he had his reward.

H. V. HICKMAN.

ALL members of the "Guy's '91 Fraternity," and a large number of other old Guy's men, must have heard of the sudden death of H. V. Hickman with surprise and deepest sorrow.

In the early eighties his was a familiar figure to all at the Hospital. He was an excellent example of the best type of medical student of those days. He was always kindhearted and sympathetic to any of his colleagues in trouble, conscientious in everything he undertook, straightforward and honest in his dealings with all, with withering sarcasm and contempt for any who did not play the game.

Although a very hard worker, he found time to play for the first Rugby team, representing Guy's on the three-quarter line in many a cup-tie. He kept himself in excellent training by running daily to and fro between Liverpool Street and the Hospital; he won many cups for running, and held the record for the mile in the Inter-Hospital Sports.

When holding the appointments of Charity, and later of H.-P., he set a splendid example to his juniors for punctuality and keenness for work.

Roll of Honour.

Died of Wounds.

Lieut. W. S. Lacey, R.A.M.C.

Wounded.

Major C. A. Pollard, R.F.A.

Captain H. B. German, R.A.M.C., attached to Leicester Regiment.

Lieutenant A. Davidson, R.A.M.C.

Appointments.

Royal Navy Medical Service.

The following appointments have been made:—

Fleet-Surgeon J. C. G. Reed to the *Thunderer*.

Temporary Surgeons:—J. A. M, Alcock to the *Vivid*, additional for Plymouth Hospital. E. G. Schlesinger to the *Europa*, additional.

Royal Naval Volunteer Reserve.

Surg. Prob. A. G. Ord to the *Forester*.

Royal Army Medical Corps.

Major A. J. Hull, F.R.C.S., and Major A. W. Gater to be temporary Lieut.-Colonels.

Major S. L. Pallant to be temporary Lieut.-Colonel whilst in command of Casualty Clearing Station.

Major M. G. Rattray, M.C., and Major T. J. Wright to be temporary Lieut.-Colonels whilst in command of Field Ambulances.

Capt. W. P. Purdom to be temporary Major whilst in command of Field Ambulances.

Temporary Lieutenants to be temporary Captains:—F. G. Cross, P. C. Litchfield, A. A. Miller, C. S. Pantin, F. B. Manser, E. G. Evans, R. Felton, B. C. Scott.

To be temporary Lieutenants:—R. S. Kennedy, F. Rogerson, J. Robertson, A. Reid, A. J. McNair (temp. Hon. Lieut.), R. Curle, J. D. Pearson, E. P. Hudson (R.F.A.).

The following temporary Lieutenants have relinquished their commissione:—W. P. Taylor, M. M. Adams, H. Tipping, J. Walker, L. S. N. Glanville.

Lieut. Cyril Francis, M.D., B.C., has been appointed Surgeon to the 20th General Hospital, B.E.F.

Capt. F. J. Tipper, Dental Surgeon, attached to R.A.M.C., to be Inspecting Dental Officer for the Eastern Command.

W. D. Macdonald has been appointed Army Dental Surgeon with the rank of 2nd Lieutenant.

South African Medical Corps.

M. M. Adams to be Captain.

I. Samuels has been appointed to a Dental Commission under the Croix Rouge Française attached to the Army in France.

Civil.

F. N. Doubleday, M.R.C.S., L.R.C.P., L.D.S., has been appointed Dental Clinical Assistant to King George Hospital.

r W. F. Colclough, M.R.C.S., L.R.C.P., has been appointed Certifying Surgeon under the Factory and Workshops Act for the Sidmouth District County of Devon.

Enlarged Prostate.

CLINICAL LECTURE BY A. R. THOMPSON, Ch.M., F.R.C.S.

I FIND that the accurate conception of enlarged prostate by students is by no means what it ought to be, and I have put down on the board here a rough synopsis of what I am going to speak about. The prostate may be enlarged, in acute inflammatory affections, in gonorrhœal or tuberculous affections, or you may get a sensation of enlarged prostate when there is a calculus present in the prostate cavity. Such a calculus I show you now. And you may get what is much the commonest form of enlarged prostate, and for which the term "enlarged prostate" should always be reserved, what I have put in capital letters here, "FIBRO-ADENOMA." That is the true enlarged prostate. For the pathology of that condition I would refer you to the writings of Col. Cuthbert Wallace. Five per cent. of those fibro-adenomata are malignant, the malignancy not being suspected. But such cases of malignant disease of the prostate do not offer any difference in symptoms from the ordinary enlarged prostate. Those of you who have any experience of thyroids will remember that a certain number of cases of apparently ordinary thyroid adenomata are found, on pathological examination, to be malignant, but their symptoms were not different from those of an ordinary thyroid adenoma, and certainly gave no clinical manifestations of malignancy during life. So it is with the fibro-adenoma of the prostate. About five per cent. of them, according to Mr. Hurry Fenwick, are malignant without giving rise to any malignant signs.

Then we have the ordinary malignant prostate which does give rise to very definite symptoms pointing to malignancy. I hope that is perfectly clear.

We will now take the symptoms of ordinary fibro-adenoma of the prostate. It occurs in elderly males. I have not seen a case of enlarged prostate under 50. The symptom which the patient complains of is frequency of micturition; especially is he troubled by this frequency of micturition at night, sometimes having to get up six or eight times. Sometimes the patient has to get up so frequently to pass his water that his sleep and, therefore, general health, is seriously disturbed. But I would draw your attention to the fact that frequency of micturition, which is usually due to over-filling of the bladder, and overflowing of the bladder contents, that frequency of micturition is by no means always associated with a full bladder; and it becomes a question as to whether under certain conditions the frequency of micturition is not the cause of the enlarged prostate, not the enlarged prostate the cause of frequency of micturition.

Another symptom which may be present in cases of enlarged prostate is hæmaturia—blood in the urine; and I mention that condition because you may meet with very considerable difficulties in the way of treating these cases of hæmaturia due to enlarged prostate. With an enlarged prostate, before passing a catheter you should always examine the abdomen; and when the bladder is full you will find, very often by a simple visual examination, an ovoid swelling at the lower part of the abdomen. You can palpate such a swelling and feel its smooth, rounded, tense outline. Sometimes the dilated bladder has an area of dulness over it; the books say always—that is not my experience.

When you consider the question anatomically, it must be merely a question as to whether the peritoneal cavity is in front of the bladder with the intestines or whether the bladder has gone up in front of the intestines. If it has gone up in front of the intestines, and has pushed the intestines aside, I am quite willing to admit

that, then, there will be an area of dulness corresponding to the full bladder; but in my experience in at least 60 per cent. of the cases, the full bladder goes up *behind* the intestines. Hence the area over it will be resonant, and you must never be put aside because a swelling above the pubis has an area of resonance over it.

Another point which is not paid sufficient attention to in the books, but which is sufficiently common to warrant my mentioning it, is that the full bladder, as it dilates, may by no means be confined to the middle line. It may pass obliquely upwards and to the right, or upwards and to the left—much more frequently to the right; and in certain cases, bladder tumours, or dilated bladders, I should say, have apparently had no connection with the real bladder. You may have an isolated swelling in the right iliac region which is apparently not of any particular connection with the bladder, and which may certainly mislead you as to diagnosis. Therefore, please remember the resonant area as possibly occurring over a dilated bladder, and remember the asymmetry of the dilated bladder.

With regard to renal complications which you may get in connection with an enlarged prostate, the clinical manifestations of these may be absent, unless an examination of the urine is made. Patients may come in with an enlarged prostate, the amount of the urea is very much increased in the blood and also diminished in the urine. And you will always, in any question of enlarged prostate, examine the blood for the urea percentage, and also examine the urine for the urea percentage.

Now we come to catheterisation of a case of enlarged prostate. You have a choice of three or four separate varieties of catheter to pass on such a condition, plus a bougie, which is, as you will remember, a solid instrument for passing along the urethra. The most usual catheter to pass on a case of enlarged prostate is a Coudé catheter. Sometimes a bi-Coudé catheter may be necessary. An olive-headed catheter may be used, and should be used with great caution; and a gum elastic catheter may also be used; but great care should be used in appropriately bending a gum elastic catheter and in softening it; and one very useful way of softening catheters is, to place the bladder half of the catheter in boiling water for a quarter of a minute; the handle is thus kept more or less rigid, and the part which is going over the prostate into the bladder is thereby rendered quite soft.

A Jacques' catheter may also be used, but I must say that I think I have had a great deal more pain—or have seen a great deal more pain—when patients have had Jacques' catheters passed on them, than with the ordinary catheters. I think I have never seen a Jacques' catheter passed without a considerable amount of pain. Apparently it is ideally the instrument. Practically in my experience it is not so good as the other catheters. The solid instrument is for the purpose of measuring where the obstruction is. If the obstruction is more than seven inches from the meatus, you may be perfectly certain that you are dealing with a case of enlarged prostate, and not with one of stricture.

There is a difficulty in catheterising these cases owing to the fact that the point of the catheter may hitch against the projection of the prostate into the urethra.

Another point is that the urethra may be very much lengthened in these cases of enlarged prostate, with the result that you have to go a little further than perhaps you feel disposed to when you are passing a catheter.

Another important point in passing a catheter for the purposes of diagnosis, and incident-

ally treatment, is the question of finding out what the urine is like; and if you wait till the last drops of urine come away from the catheter, you will find in the last drops of urine in a great number of cases practically pure pus. On this, Sir Henry Thompson recognised as a possible condition associated with enlarge prostate what he called "basic cystitis." I believe myself that if there is cystitis present in such cases it is general; but in a large number of cases I am quite satisfied that there is no active form of cystitis, and that it is merely pus from some sub-acute or chronic cystitis which has sunk to the bottom of the bladder, and which is drained only when the last drops are drained away.

I do not think there is any necessity to call in a special condition of basal cystitis to explain those last drops of pus which come away when you have drained a bladder which is overfilled due to enlarged prostate.

Now with regard to rectal examination, I would refer you to these two diagrams, labelled "Rectum I." and "Rectum II." It is quite clear to my mind that clinicians have a different idea and conception of the rectum from what anatomists have; and I believe that the two conceptions may be standardised if we remember that the direction of the anal canal may vary. Sometimes it is directed downwards, as in Rectum I, with a slight inclination forwards. At other times it is directed downwards with a *strong* inclination forwards; and in order to a great extent to get over this difficulty, I always adopt and try to teach the dressers a standard position for making a rectal examination. The patient leans over a couch with his face towards it, his lower limbs slightly separated, and you, standing behind him, gently introduce your right index finger into the rectum, whilst with the left hand you feel the symphisis pubis.

Now let us see how these two different types of rectum affect an examination. In the first place, I think you will admit, in both the diagrams, that the prostates, which are these yellow masses, are roughly about the same size. You put your finger into Rectum I, and you feel at once an enlarged prostate. You put your finger into Rectum II, and your finger may pass an enlarged prostate without your recognising that the prostate is enlarged; and those are the first difficulties with regard to rectal examinations.

"R.E." sounds a very simple thing. In reality it requires a considerable amount of care. You will have a standard position, and you will have a standard method of examination. The other difficulty in connection with the rectal examination is one that I do not think can be got over by a standard position or a standard examination, and it is this. The full bladder not only projects up into the abdomen, but it also projects down towards the peritoneum. If it is hard by the abdomen it will be equally hard by the rectum; and a patient may present himself with an enlarged bladder, and when you examine his rectum you will apparently feel an enlarged prostate. Such cases are not uncommon. You pass a catheter, obsessed with the idea that there is an enlarged prostate, and you meet a stricture. Such a difficulty which occasionally occurs is due to the large bladder not only dilating upwards, but also downwards, and pushing what may be a normal prostate into the rectum. Those are the difficulties with regard to rectal examination.

The difficulties of a catheterisation and of a rectal examination are so great and so common that before making an absolute diagnosis of enlarged prostate, I always like to do a cystotomy and examine with the cystoscope. You will see the hypertrophied and fasciculated bladder. You will see any signs of chronic cystitis there may be, and you will also see the enlarged prostate projecting into the bladder,

and most of its surface fully illuminated by the cystoscopic light.

Now that remark may not appeal to people who have not done cystoscopies with me, and, therefore, I will not labour it at the present moment. But you may be perfectly certain that if with a cystoscopic examination the projection of the prostate into the bladder is fully illuminated, that you have got a case of enlarged prostate to deal with, and not a normal condition.

Moreover, the advantage of a cystoscopy is that with a comparatively small enlargement of the prostate you may get quite well-marked symptoms of enlarged prostate. Such a case is illustrated, I think, perhaps best in this specimen which I will hand round. I am afraid the specimen is slightly tilted, but this is roughly a drawing of it. The two large masses, as you will see, are the lateral prolongations down by the side of the urethra. I do not want you to think the urethra is present here, because it is not. That ought to be in dotted lines. Here, projecting up, projecting towards the label in this specimen I will hand round to you is a very well-marked ball-valve adenoma. That was not an enlarged prostate per rectum. Cystoscopically we found that projection of the ball-valve adenoma into the bladder. The symptoms of obstruction in this case were very well marked.

Whilst those are the classical symptoms and signs of enlarged prostate, there are two conditions which produce anomalous symptoms. You may be perfectly certain that after a careful examination you are dealing with an enlarged prostate; nevertheless, the bladder is not dilated, but the patient still suffers from frequency of micturition; but the frequency of micturition is entirely different from the frequency of micturition occurring with ordinary enlarged prostate, and it more closely approaches the frequency of micturition which is associated with stone, viz., that the frequency of micturition with stone is during the day, and hardly at all at night. Now that is very important. You may take it as a rule that when a patient presents undoubted signs and symptoms of enlarged prostate, but his bladder shows no evidence of dilatation, you may take it that that man has probably stones as well.

I will hand round this tin containing three stones which I removed from a patient who presented all the signs and symptoms of enlarged prostate except that he had a good deal of pain and frequency of micturition chiefly during the day, but there was no evidence of a dilated bladder, and I said, "I am sure there are stones there," and, as you see, there were.

Cystitis, when it is present, as it may be if the bladder becomes infected, also produces anomalous symptoms in exactly the same way as stone.

Those are the anomalous symptoms which are produced by certain conditions which you will be perfectly certain about in the vast majority of cases.

On the other hand, stone in the bladder may give rise to the same symptoms as enlarged prostate. I have only met, however, with one such condition; and you will easily understand, when I hand round the specimen, why it was that the symptoms of enlarged prostate were present. There is a specimen of two stones which I removed from the bladder of a man who presented all the symptoms of enlarged prostate. When one stone did not act as a ball-valve, the other did; and owing to this obstruction by those stones, which are of a very peculiar conical shape, he got all the symptoms, as I say, of enlarged prostate, without the prostate being enlarged when we cut down upon it.

The question of the anatomy of enlarged prostate I will leave with the following exception. I would draw your attention to this

marked recess behind the enlarged prostate in the dilated bladder. That recess is known as the "bas fond" of the bladder. In that recess stones may form and stones may accumulate; and that is another advantage of performing a cystoscopy on these cases of enlarged prostate by means of a special retrograde cystoscope, which, in my opinion, is a most satisfactory instrument; you may then see behind the prostate, and you may then be able to see a stone.

You will be, perhaps, interested in the question of the treatment of enlarged prostate. Some patients go on very well with being left alone. I think if patients are left alone with regard to enlarged prostate, very, very careful advice should be given to them with regard to diet and with regard to the passage of water.

It is possible that you may be able to get over the ball-valve obstruction of the enlarged prostate by means of position, and the erect position may be by no means the most suitable for such cases. Or you may start the patient on catheter life—euphemistically called "catheter life." I am perfectly well aware that a great number of patients have lived for 16 or 18 years with catheter life; still, it cannot be regarded as altogether a pleasant form of living, or as a very safe form of living. The man has a very precarious existence who lives a catheter life. The risks of setting up hæmorrhage, the risks, above all, of setting up sepsis, in people whose kidneys are already directly affected by the back pressure, are so great, that an operation, serious and severe as it is, offers, in my opinion, a much better prognosis than so-called catheter life. But you are up against a serious question, because, however careful you are with regard to a preliminary examination, however quick you may be at the operation, and however well your dressers act after the operation, you will be up against a certain number of disappointments. The disappointments are less the more careful and the quicker you are; but there is no questioning the fact that removal of an enlarged prostate is a very serious operation.

With regard to an operation, I will just go through what the usual plan of examination and treatment is at our Out-Patient Department. The patient is examined and catheterised at Out-Patients. His name is then taken for admission, and he is admitted in due time. But no instrument is again passed unless retention calls for it. The patient's blood is carefully examined by Dr. Ryffel with regard to its constitution. The patient's urine is examined by the dresser. Any abnormality is noted. With regard to the urea in the blood, if that has appreciably increased, you will adopt one of two methods: either teach the patient to pass a catheter and let him enter upon catheter life, or do a supra-pubic cystotomy and get rid of the back pressure due to the enlarged prostate. I would refer you in this connection to the case of a man who was admitted some six months ago with clinical manifestations of uræmia in that he was rambling and drowsy, and with pathological manifestations of uræmia in that the urea in his blood was very much increased in quantity. A supra-pubic cystotomy was performed, a drainage tube put in, and a supra-pubic fistula allowed to form. Within three weeks that patient's urea in the blood had gone down to normal, and within six weeks he was perfectly well and out of the hospital. Thus, please remember that, because a man has got uræmia, he is not necessarily a hopeless case, and a supra-pubic cystotomy may do a great deal of good.

With regard to the operation for the removal of an enlarged prostate, a spinal anæsthetic is most useful. I have given, three-quarters of an hour before the operation, a quarter of a grain of morphia, a hundredth of a grain of atropin, and a hundredth of a grain of hyoscin. This last is, perhaps, rather a large dose. The

spinal anæsthetic is done in the usual way, and the operation is begun by passing a catheter and dilating the bladder with air. The person who is dilating the bladder with air, which is done with an ordinary boiled enema syringe and catheter, should keep his left hand upon the abdomen to feel that the bladder does not get over-filled. The usual incision is made as for opening the bladder, but I now use a sharp tenotomy knife for going through the bladder wall, the reason being that an ordinary knife so frequently pushes the loose mucous membrane, which is only supported by air, in front of it, that there may be difficulty in making a complete incision into the bladder; and for anybody who is going to incise a bladder under such a condition, I would strongly recommend the use of a sharp-pointed tenotomy knife. The bladder being then opened, the walls are secured with Lane's forceps, the finger is introduced into the bladder, and any stones which may be present are removed. A curved pair of scissors is then introduced into the bladder, and cuts through the mucous membrane of the bladder wall just in front of or just behind the urethra. The finger is then very carefully introduced through the incision at the base of the bladder, and the adenoma of the prostate enucleated. A typical operation takes, with spinal anæsthetic and dressing, under twenty minutes.

With regard to after-treatment, you may either, in certain favourable cases, sew up the bladder and attempt primary union, although such a method gives rise to great labour on the part of the dresser, and some anxiety on the part of the surgeon for the first two days. If the case goes on well the results are such an improvement, both as to labour involved afterwards and the happiness of the patient, and also the life of the patient, that in suitable cases I always try for primary union; even if the wound breaks down a little, the results are better than leaving them open. But, of course, there are a large number of cases in which it would be decidedly wrong to do anything but insert a large drainage tube.

I should not sew up the bladder with a case of cystitis; I should not sew up the bladder where there was a good deal of hæmorrhage; but in certain cases there is no doubt that primary union of the ends of the bladder after enlarged prostate ought to be aimed at. If you use a drainage tube, it should be large, and I think a catheter ought to be passed. Do remember the catheter should be in the bladder and not in the cavity left by the prostate.

Gentle funnelling of fluid through the catheter, bladder, and drainage tube should be performed two or three times a day for the first two or three days; but an attempt based on physical principles should be made to drain the bladder through the catheter and tube attached to it as far as possible. I do not mean the drainage tube—do not be confused about that—I mean the catheter and tube attached to it; and for that purpose it may be necessary to be continually adjusting the catheter so that the eye of the catheter is in the most favourable position for draining; and you must be very careful not to get an air-block in the catheter or its tube.

With regard to the results of enlarged prostate, I have said already that it is a serious operation. Patients may die from shock; patients, especially in cold weather, may die from acute bronchitis; but these cases have nothing to do with the operation in that I have had a death from acute bronchitis occur three weeks after the operation. Deaths may occur from hæmorrhage, shock, or uræmia, or pulmonary embolus.

With regard to prognosis, I should say that more than two-thirds of the cases did well after the operation, and their life is very much prolonged, and in the vast majority of cases, prolonged pleasantly.

With regard to the sexual question, that does not quite practically arise, because, as I say, the patients are old. But cases where patients have maintained certain sexual desire if not sexual function after removal of the prostate have occurred in my practice.

With regard to the age, you can operate, provided the kidneys are alright, at any age. I have myself operated on a patient aged 84 with primary union; but if you had seen that man you would have agreed with me that he was 54. He was 84 according to Somerset House; he was 54 according to the arteries and his bladder, and generally. There was no credit in doing it because he was 84. I have heard of one man operated upon whose age was 94.

Honours.

Military Cross.

Temp. Capt. Harold Ackroyd, R.A.M.C. For conspicuous gallantry and devotion to duty during operations. He tended the wounded under heavy fire, and finally when he had seen that all our wounded men from behind the line had been got in, he went out beyond the front line, and brought in both our own and enemy wounded, although continually sniped at.

Temp. Lieut. Richard Felton, R.A.M.C. For conspicuous gallantry and devotion to duty during operations. He tended the wounded during an intense bombardment, and a few days later, when a shell blew in the orderly room killing three men and burying the remainder, he rescued the latter under most dangerous conditions. But for his pluck and devotion to duty many more lives would have been lost.

Capt. A. Stephen Liebson, S.A.M.C. For conspicuous gallantry and devotion to duty when tending the wounded during operations. Though himself wounded and with nothing but a small trench to work in, he carried on during several days under heavy shell and sniping fire with the greatest courage.

Mentioned in Despatches.

The names of the following medical officers are mentioned in despatches received from Lieut.-General Sir Percy Lake, K.C.B., in connection with the operations in Mesopotamia and the relief of Kut-el-Amara: Capt. F. C. Fraser, I.M.S., Major J. H. Horton, I.M.S., D.S.O.

Demonstration in Clinical Medicine.

By Dr. LAURISTON SHAW.

1. *A Case of Splenectomy.*—Mr. Rowlands removed this boy's spleen at my suggestion about six weeks ago. As you see the patient now, he looks in excellent health except that his mucous membranes are somewhat pale. His medical life up to the date of the operation was marked only by three important events: At the age of 2 years, 8 years, and again two months before his operation (his present age being 16), he lost large quantities of blood which came through his mouth. His mother does not know whence the blood was supposed to have come on the two earlier occasions, but she remembers that the hæmorrhage was severe and caused considerable anxiety. Dr. Proctor Sims, who sent the boy to me, was called to him on the last occasion and recognised the condition as one of profuse hæmatemesis. As soon as the bleeding ceased, a careful general examination revealed the presence of a *splenic tumour*, but no other obvious abnormalities except the anæmia. Dr. Barty King, who now investigated the case in his Out-Patient Department, had a complete blood examination made and found a marked anæmia of the chlorotic type, without increase of white blood corpuscles or any striking modification in the proportional number of varieties of leucocytes. A diagnosis was, therefore, made of *splenic anæmia*. The question was then raised as to the treatment of the case by splenectomy, and I was asked to admit the boy into a medical ward in order that the matter might be considered.

On admission Dr. Nicholson kindly examined the blood for me and confirmed the main features of the previous report, except that there

was an increase both in the number of the red cells and the percentage of hæmoglobin, a change which might well be accounted for by the patient's gradual recovery from the loss of blood he had recently sustained.

On investigating the case further we found an extremely well-defined splenic tumour reaching to an inch below the level of the umbilicus and about two inches to the left of the middle line. A deep notch on the anterior edge was palpable.

The case reminded me of a little girl about 10 years of age who was under my care in Mary Ward more than 15 years ago, and whose case I reported in the 56th volume of the Guy's Hospital Reports as a Case of Splenic Anæmia. She had a large spleen and repeated attacks of hæmatemesis, one of which ultimately proved fatal. The question of splenectomy was raised and discussed with a surgical colleague, but I am sorry to say we decided against it.

In reporting the case of this girl I expressed the opinion that at that time two totally different classes of case were being diagnosed as splenic anæmia. "In one group the course of events appears to be (1) large spleen; (2) anæmia; (3) general hæmorrhagic tendency; in the other, (1) large spleen; (2) local gastric hæmorrhage; (3) anæmia."

I have seen a good many examples of the first group since that date, but this is, I believe, the first case belonging to the second group that I have had under my care since the little girl in Mary Ward. To emphasise the special features of the case and in the hope that the Registrars will open a special heading for this type of splenic disease in their indices, I have asked my ward clerk to make the official diagnosis of "Splenomegaly with recurrent hæmatemesis." If I am right, the causation of the hæmorrhage is, of course, very different in the two groups. In the group to which this boy belongs there is probably some mechanical obstructive cause depending on the intimate vascular relations of the stomach and spleen. In the other group the abnormal condition of the anæmic blood causes it to transude too easily through normal tissues without any breach of surface or undue fulness ol vessels.

Although splenectomy seems to be the established treatment now of all forms of splenic anæmia, we may, I think, recommend the operation with much greater confidence in the class of case I am now showing you than in those in which the anæmia precedes the tendency to bleed. The risk of troublesome hæmorrhage at and after the operation should be less. The removal of the cause of the hæmorrhage is more certain.

I asked Dr. Fawcett, Mr. Rowlands, and Dr. Proctor Sims to meet me in consultation over the case, and, as a result of our deliberations, it was decided to operate.

In recommending operation we have had two main objects in view: one to remove the risk of further attacks and possibly a fatal attack of hæmatemesis; the other to save the liver from the harm which seems to come to it in some cases of prolonged enlargement of the spleen. There is some reason to believe that in Banti's disease, a mysterious condition in which there is enlargement of both liver and spleen, the hepatic trouble is dependent upon the constant transfer of toxins from the spleen to the liver by way of the portal vein. Our boy's liver at present seems perfectly normal; at least, it is not enlarged or tender, nor is there any jaundice. If our patient did actually stand in any danger of developing Banti's disease later on, this danger should be averted by splenectomy.

Recognising that the severity of the operation itself depends upon the size of the spleen and the density of the adhesions, we tried beforehand to estimate these points. The spleen moved freely on respiration, and I have already

told you roughly its surface relations. Mr. Rowlands did not seem in the least appalled at the size of the organ; in fact, as large spleens go in blood conditions it was decidedly a moderate enlargement. Nevertheless, to the non-surgical on-looker the surgeon's task, when he comes to it, appeared sufficient, and the tying of numerous adhesions was tedious. The spleen when removed weighed 24 ounces, which is just about four times the normal weight for a boy of this age.

The patient stood the operation well, and Mr. Nicholson having allowed two or three weeks to elapse in order to eliminate the effects of hæmorrhage at the operation, now reports a distinct improvement upon the results of the blood examination made on admission. Dr. Proctor Sims has promised to try and keep the boy under observation for as long as possible in order to watch the progress of the case.

2. *A Case of Mediastinal Tumour.*—This cheerful and robust-looking man, æt. 43, who says he has lost no flesh and only feels weak because I keep him in bed, states that he was quite well six months ago when he began to have a dry cough. During the last three months he has become short of breath on exertion, and sometimes when he coughs he brings up a little blood. A few weeks before admission he noticed a swelling above his left clavicle.

On admission this swelling is a conspicuous feature. You can all see it. It is a hard flat mass, the size of the palm of one's hand. It is nodular on the surface with clearly defined edges. The skin dimples when one tries to move it over the tumour, and the whole mass seems lightly attached to the deeper structures. There is a similar smaller mass in the left axilla. The superficial veins over the surface of the chest are plainly seen to be dilated. I think you can recognise as I percuss that the note over the upper part of the sternum and of the left chest is distinctly duller than on the right side.

An immediate diagnosis of mediastinal tumour can, therefore, be made, and, further, you cannot doubt that of the common causes of such tumours—aneurysm and growth—we have here to deal with a growth. Note, however, the absence of pain and wasting so common in malignant disease.

We shall try and establish the seat of origin of this growth. The three common sites are œsophagus, mediastinal glands, and bronchus. The presence of hæmophysis and absence of dysphagia incline us to regard the bronchus as the primary seat of mischief. What, then, is the large area of dulness due to? All abnormal dulness in the thorax is essentially due to absence of the normal air from the lung. This may, in cases of intra-thoracic growth, rarely be due to actual infiltration and replacement of lung tissue by neoplasm. Much more commonly it is due to compression of the lung or collapse of the lung. The air may be squeezed from the lung by the gradual pressure of the tumour itself, and then the amount of dulness is directly in proportion to the size of the growth. But this is not commonly the case. Extensive areas of dulness such as we have here are more usually caused by serous effusion into the pleural cavity, the fluid then being the compressing agent. This would be unlikely when, as in this man the dull area is at the apex. A more likely cause of apical dulness would be an airless condition of a portion of the lung produced by complete occlusion of its supplying bronchus —a condition of collapse. In these circumstances an extraordinarily rapid increase of the dull area may be noted. We hope by carefully watching the case, and perhaps with the assistance of the X-ray Department, to make a more complete diagnosis than that of intra-thoracic growth at which at present it stands. We shall not put the patient to much discomfort in our further researches, inasmuch as we are quite confident that no increased knowledge on our

part will give us greater power in curing or relieving his condition.

3. *A Case of Double Optic Atrophy.*—This little girl, aged 8 years, became rapidly blind about three months ago, and is now reported by Mr. Ormond to have secondary optic atrophy which, as you know, means that the atrophic condition has followed upon optic neuritis. The child is said to have been quite well till seven months ago when she had a fall of a considerable distance, struck her head, and was unconscious for a time. Since then she has suffered from headache, vomiting, and fits, as well as from the blindness. Inasmuch as the blindness, as Mr. Ormond tells us, was due to optic neuritis, there has been absent only one of the five hippocratic signs of cerebral tumour, "headache, vomiting, vertigo, optic neuritis, and fits." I do not feel sure, indeed, that the child may not sometimes have vertigo; it is a difficult subjective symptom to elicit from a small child.

Shortly after admission, Dr. Cameron took charge of my wards, and, struck by the obese condition of the girl and her tapering fingers, raised the question whether the tumour was situated in the pituitary body, and her condition one of hypo-pituitarism. In the X-ray Department, however, no change could be detected in the sella turcica, nor did she react to hypodermic injections of pituitary extract. She was already quite blind, so that we were unable to gain any assistance from investigation of her fields of vision. It is too early yet to say whether her sexual development will be delayed. I do not think we can give a confident negative answer to Dr. Cameron's question.

There is, however, a note in my ward clerk's excellent report which raises another question as to the situation of the intra-cranial tumour of whose existence we are confident. "Ever since the fall the child has been unable to stand without holding on to something. Her body sways about when sitting up." These evidences of incoordination suggest that the tumour may be situated in the cerebellum. Before we knew anything about the functions of the pituitary gland and its destruction giving rise to infantilism, it was a common belief that cerebellar tumours were associated with obesity.

Looking back over the record of this case, one recognises two opportunities that have been missed: one in the region of diagnosis, the other in treatment. In the days when the child was losing her sight, careful investigation of the field of vision might have revealed the existence of the special form of heteronymous hemianopia which results from pituitary tumours. In those early days, too, before the optic neuritis began to pass on to optic atrophy it would have been well worth while considering whether a decompression operation might have saved the patient's vision. I have now seen several cases of what appeared to be cerebral tumour in which all the symptoms have disappeared except the blindness due to optic atrophy. It seems as though many of the symptoms of cerebral tumour are due, not to the existence of the tumour, but to its gradual increase of size. In rare cases this increase ceases, and it is thus a thousand pities if a timely operation for the relief of intra-cranial pressure has not been performed in the hope of arresting the changes in the optic nerves.

Three Uncommon Cases.

THE three cases noted below may interest your readers, and as they occurred in my private practice, I feel I may send them without consulting the censor, although at present I am serving in the B.E.F. somewhere in France.

1. *Pneumococcal peritonitis.*—Miss L. M., æt. 44, came down to Bournemouth on October 26th, 1915, to look after an aged relative, and developed an acute attack of lobar pneumonia.

She was a thin, unhealthy, and badly-nourished person. The pneumonia was on the left side, and the whole of the left lung was involved. The temperature fell by crisis on the seventh day; two days before this she complained of abdominal discomfort and had a sharp attack of diarrhœa which lasted about thirty-six hours. On the evening of the eighth day the abdomen was distended and tympanic, and did not move well on respiration. Her temperature ran up to 102·6° F.; pulse 110; respiration 30. She complained of great pain in the abdomen, and it was worse in the right iliac region. On palpation there was marked rigidity in the right iliac region, and a hard swelling could be made out on the left side low down in pelvis. Rectal examination revealed nothing but general tenderness. It was impossible to press down on the abdomen very much on account of the marked tenderness.

Owing to her condition, I was not anxious to let the patient take an anæsthetic, so temporised for twenty-four hours longer. She, however, became worse, the bowels did not act, and an enema that was given was returned with very little fæcal matter; she also vomited and could keep nothing down.

On November 5th chloroform was given, and I made an incision on the outer border of the right rectus about 5 inches long. When the peritoneum was opened, thick curdy pus came away. All the intestines were covered with lymph and matted together; the cæcum was fixed down and the appendix dilated and very adherent; the left ovary was solid, and was removed—it was the size of a cocoanut. On trying to free the appendix it burst, and the cæcum was torn; all the intestines were soft and very friable. The small rent in the cæcum was sutured, and as the patient's condition did not favour prolonged operation, pus was swabbed out of the abdomen, and a big drainage tube inserted into the pelvis and a smaller one was left in contact with the sutured cæcum.

Next day patient's temperature 100°; respiration 24; pulse 110. She absorbed two pints of saline during the night per rectum, but this had to be discontinued as it returned. The sickness ceased, and the patient said she felt much better and more comfortable. Forty-eight hours after the operation, fæces were discharged from the wound and a regular fæcal fistula was established. Very little discharge came from the big tube in the pelvis. The wound was kept clean with peroxide of hydrogen and weak carbolic. About three weeks after the operation the bowels acted normally and patient gradually began to mend and returned to her home.

The pus found in the abdomen grew pure culture of pneumococci, and the patient stated she had had attacks of pain in the right iliac region on several occasions, but it was never severe enough to keep her in bed. Pneumococcal peritonitis (?starting in appendix) does not appear to be very common. Clifford Allbutt's System of Medicine puts it at ·3 per cent. as occurring after acute lobar pneumonia.

2. *Obturator hernia.*—Mrs. E. H., æt. 51, was admitted into the Royal Victoria and West Hants Hospital under me as a case of intestinal obstruction on January 1st, 1916. She was a stout, well-nourished looking person, and had a typical abdominal face, but complained of very little pain (before coming in she had been given I.M.H. gr. $\frac{1}{4}$). She vomited at intervals dark brownish fluid with a slight fæcal odour. The abdomen was uniformly distended and nothing could be felt externally, per rectum, or per vagina. The pulse was 84; temperature 99; respiration 24.

The patient gave a history of sickness for three days, had passed a little wind per rectum two days before admission, but no fæces for three days. There had been great pain which

came on quite suddenly while she was lifting a weight. The pain was all in the epigastrium. Enemata gave no result, the injection being returned free from fæcal material.

Operation.—This was performed two hours after admission. The abdomen was opened in the middle line, the incision extending from the umbilicus to pubes. The large intestine was found collapsed; the small slightly distended. While examining the cæcum I found the ileum about six inches from the cæcum, bound down. On more careful inspection I found about an inch of it had been nipped in the obturator foramen. Careful and steady traction soon released it; it was bluish in colour, otherwise healthy, showing only the marks of pressure. When the bowel had been released, the obturator muscle contracted, and the opening could only be found by tracing the obturator vessels and nerve. The abdomen was closed, and the patient made an uneventful recovery.

Rose and Carless state that this variety of hernia is usually found in elderly females P.M., and is sometimes diagnosed by pain down the inner side of thigh in the course of the obturator nerve. In this case all the pain was in the epigastrium.

With regard to treatment of this rare form of hernia, Rowlands and Turner in Jacobson's Operative Surgery describe two methods (1) the *external*, by cutting down on the swelling which will be found inside the position for the femoral ring, reducing bowel, ligaturing and cutting away sac and closing the aperture with buried suture; (2) *internal*, by median incision into abdomen and withdrawing the bowel from within.

In this case there was no swelling on the inner side of thigh near the femoral ring, and it is interesting to note that the so-called sac was reduced with the bowel and the opening made by the hernia closed entirely on the reduction of the bowel.

3. *Acute appendicitis complicated by tubal gestation.*—Mrs. H., æt. 24, married two years, but had no children, was first seen by me on the 22nd December, 1915. The patient was a healthy-looking girl, who complained of pain in the lower part of her abdomen coming on at intervals; the pain was more on the right side side than the left. Temperature 99; pulse 100; respiration 24. Between the paroxysms of pain the patient felt quite well and comfortable; the pain had been on and off for two days. The periods were regular, the last ending two weeks previously. On respiration the lower part of the abdomen did not move well; there was marked tenderness and rigidity in the right iliac region and over bladder. The patient had passed water quite easily and the bowels had been opened on the morning of 22nd December.

Per rectum, a roundish swelling could be easily felt on the right of the uterus; it was tender and much pain was caused by slight pressure. Two hours after seeing the patient I opened the abdomen by an incision on the outer border of the right rectus. On dividing the peritoneum, a little straw-coloured fluid escaped, but no blood. The appendix was found inflamed and dilated; it was, on opening it after the operation, found to contain pus; it was removed. On putting my hand into the abdomen to examine the right tube and ovary, some dark-coloured blood welled up. The tube was found to be dilated to the size of a small hen's egg; it was ligatured and removed. The wound was closed. Continuous saline and glucose was given per rectum. The patient made a good recovery.

One can not look upon either acute appendicitis or tubal gestation as rare cases, but the combination of the two is, I think, interesting and not common. In conclusion, I might say I could get no history of previous attacks of appendicitis.

W. S. RICHARDSON,
Capt. R.A.M.C.T.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Laboratory Manual in General Microbiology. Prepared by the Laboratory of Bacteriology, Hygiene and Pathology, Michigan Agricultural College. (Messrs. Chapman & Hall.) Pp. 418. Price 10s. 6d.

This book is not primarily intended for the use of medical students. It is a practical guide to the laboratory courses in bacteriology at the Michigan Agricultural College, and is not in any way confined to the study of the pathogenic bacteria usually included in the bacteriological classes attended by medical students. Scientific agriculture in the United States must have reached a very high pitch if this book gives a fair example of the attention devoted to microbiology in an agricultural college.

The essentially practical character of the work is apparent from the very first page which is a reprint of the Laboratory Rules at the Michigan Agricultural College. Throughout the book there are precise practical directions to aid the student in his work.

The book is divided into three parts. Part I. deals with the preparation of media and laboratory methods for the isolation and staining of micro-organisms. Part II. is the physiology of micro-organisms and deals with enzyme action and the effects of heat, cold, light and antiseptics on micro-organisms. Part III. is applied microbiology. A considerable section deals with the microbiology of water, soil, and milk.

The book is well illustrated, and a most excellent feature is the large number of references given to other works at the end of each section. Reference is made easier by the numbers of the pages in the works referred to being given, so that there is no time wasted in looking up any particular subject. Among the references are many works by English as well as American bacteriologists.

Anatomy, Descriptive and Applied. By Henry Gray, F.R.S. Nineteenth Edition. Price 32s. net.

The latest edition of this classic work retains the same general arrangement of material as the eighteenth edition published in 1913. The length of the book has not been increased, but the text has been re-written in places and 80 new figures have been introduced; about 60 of these replace older illustrations.

The new terminology has been definitely adopted, and the glossary of the Basle anatomical nomenclature which appeared at the end of the eighteenth edition has been omitted. This is an omission which may, perhaps, be regretted by those who learnt the old terminology, but where the old and new terminologies differ the old name appears in brackets, so that the book can still be used by those familiar only with the old terminology.

The number of coloured illustrations has been increased from 431 to 499. The new figures are fully up to the high standard which has been so long a feature of this standard work.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

DEAR SIR,—May I congratulate you on the Special Number of the GAZETTE? It is a first class number. I'm so glad you've got out a good list of Guy's men who are serving. I didn't get one of your post cards, otherwise I'd have replied at once.

There are one or two omissions in the list that, perhaps, you'd be glad to have a note of for future publication.—

I.—I am a Captain Special Reserve—not temporary. I was mentioned in despatches last year. I am attached to No. 8, C.C.S., as Surgical Specialist.

II.—W. Johnson, Capt. R.A.M.C., S.R., 58th Field Ambulance. Military Cross.

III.—R. Sefton Cooper —— R.A.M.C.

No. 8, C.C.S., Yours faithfully,
19th October, 1916. G. T. MULLALLY.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Birth.

TIPPER.—On October 8th, at Graroda House Nursing Home, Southsea, wife of Capt. F. J. Tipper, R.A.M.C., of a son.

Deaths.

HICKMAN.—On Oct. 16th, at The Hollies, Wanstead, N.E., Herbert V. Hickman, M.B. Lond., aged 54.

HOLLANDS.—Killed in action on the 12th October, 2nd Lieut. Wilfred George Hollands, Royal Fusiliers.

KNOWLES-JONES.—On the 25th inst., at Ridgemount, Bournemouth, John Knowles-Jones, M.D., M.R.C.P.

THOMSON.—On October 21st, at 207, Lowestoft Road, Gorleston-on-Sea, David Thomson, L.R.C.P. & S. Edin., L.F.P.S. Glasgow, aged 55.

J. J. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

AT the present time it is still impossible to estimate the nation's losses in men and material, but even if the war ended to-day the number of killed would form quite an appreciable proportion of the total male adult population, while if the war lasts another year or more with the present rate of wastage this country may ultimately lose one and a half to two million lives. Such a loss, together with the incalculable loss in material, is bound to react very unfavourably on the development of this as of every other belligerent nation.

If the nation is to recuperate as quickly as possible we must employ the greatest care in economising our infant life. During late years a great deal has been done in teaching mothers how to look after their children, but less attention has been paid to the care of women during pregnancy. Yet upon this depends a great deal of the nation's loss in fœtal mortality, and even if a child is born alive, its existence may be jeopardised by unfavourable prenatal conditions.

Under present conditions the greater number of expectant mothers among the poorer classes are never seen by a medical man until labour has commenced. The nurse, often unqualified, then sends for a doctor who in many cases arrives too late to save the life of the baby if it is endangered by some complication. If, however, all pregnant women underwent a routine examination some time before labour, as is done in the practice of most lying-in hospitals, such difficulties as malpresentations and abnormal maternal conditions would be detected in time to remedy them and thus avoid much unnecessary risk both to mother and child.

There are difficulties, however, in securing such a routine examination during pregnancy. Even with the expectation of the maternity bounty women are unwilling to go to the expense of systematic medical care before their delivery. Further, the already hard-worked panel doctor would not welcome such an addition to his duties. The obvious solution would appear to be the institution of a state paid medical officer who in a certain district would give free attendance during pregnancy. The assurance from such an authority that all was well would do a great deal in relieving an expectant mother's natural anxiety, while he would be able to detect and treat abnormal presentations and complications of labour such as contracted pelvis, albuminuria of pregnancy, or cardiac disease. Even such a comparatively common condition as a breech presentation causes the

death of the child in from 7 to 25 per cent. of cases of its occurrence. If, however, the mother was kept under observation during the later stages of pregnancy such a presentation need hardly ever complicate labour.

The appointment of such an authority carries with it as a corollary the existence of institutions in which suitable cases could be looked after before they come to term. Such institutions could be of the same status as fever hospitals and treatment in them must not brand the inmate as a pauper.

If some such system as that outlined above could be adopted, we have to consider how far pregnant women would take advantage of it. No doubt if the scheme were properly advertised a large number would submit themselves to examination voluntarily, but in these days when our personal liberties have been already so far encroached upon, it is only a short step to introduce the compulsory notification of pregnancy, and attendance by a medical man before labour commences. The scheme is one which should commend itself to practitioners, for it would have no effect on practice among the upper classes where a medical man is already nearly always in attendance during pregnancy, while in practice among the poorer classes it would only mean that doctors would be less troubled by difficult and prolonged labour cases, while they would still attend all normal cases. The exact number of lives which could be saved to the nation cannot be exactly estimated; but when we remember that there are about 4 per cent. of presentations other than vertex, besides large numbers of contracted pelves, all of which greatly increase the risks to the child, it is obvious that by some such means, something might be done to diminish the effects of the fall in the birth rate which is sure to occur after the war and which has already begun.

We publish in this issue an interesting address given by Dr. Craig to a large audience on the subject of the National Mission. Everybody, whether in agreement with Dr. Craig's views or not, found the meeting stimulating and interesting. A second address on the same subject will be given in the College Smoking Room at 8 p.m. on Wednesday, December 13th, by the Rev. William Temple, Rector of St. James', Piccadilly. The chair will be taken by Col. Charters Symonds, C.B., Consulting Surgeon to the Hospital. We hope in due course to publish Mr. Temple's address, but this should not deter anyone from being present. Mr. Temple is the author of many well-known books on the broader aspects of religious questions, and we can confidently predict that no one who attends the meeting will regret it.

We enclose with this number an appeal for subscriptions to the Landon Tea Fund. For many years the Children's Tea and Christmas Tree in the Out-Patients' Hall has been one of the red letter days in the lives of thousands of children from Bermondsey and Southwark. The great increase in the cost of food will necessitate more subscriptions this year than ever, and we have no hesitation in appealing to the generosity of all past and present Guy's men to raise the necessary funds.

All Guy's men and nurses who have been at the hospital during late years will hear with great regret that Miss L. V. Haughton, who has been Matron of Guy's Hospital for nearly ten years, is seriously ill. We hope that her recovery will be speedy, and that we shall soon see her again able to resume her active duties among us.

We call attention to our announcement in another column of the subject of the Astley Cooper

Prize. Now that so many Guy's men are on war service, where they have unrivalled opportunities for the study of war wounds from their own observations, we feel sure that there are many who, in spite of the difficulties imposed by official red tape, will collect and publish their cases, and may ultimately find themselves in a position to compete for the Astley Cooper Prize.

We are glad to hear that Capt. J. F. Venables, who has been seriously ill in Egypt, has now recovered and is in charge of the Military Hospital at Swanage

The letter which we reproduce below was received by an old Guy's man in practice in the East. It almost rivals some of the letters sent to the O.P.O.'s. It runs as follows:—

Dear Sir,—Your patient Mr. Shanket Hasan ate your medecine 3 times and every time he had to return it, but after every return the ache increased a little and this 3rd return had the food which he had taken four days ago.

The stomach is still heaving up and the bowels roam in all the stomach. Now he has got appetite so kindly let me know whether he should eat or not and what food should he take. Can he take vinigar and soup and what medecine should he take now.—I am,

Yours obediently,

Ahmed Hasan.

The suggested diet of "vinigar and soup" would certainly seem to require some medicine to prevent its return.

Notice.

We regret that in our last issue we announced that Dr. N. Mutch, M.D., M.R.C.P., had changed his address from Hamilton Lodge, Hanger Hill, Ealing, W., to Lydstep, Sheen Road, Richmond. This change of address referred to Dr. R. S. Mutch, M.D. We offer our humblest apologies to Dr. N. Mutch for the inconvenience which our error may cause him.

Some Diseases which have become common among Soldiers in this Country.

I.—AMŒBIASIS.

Most of the men who join the R.A.M.C. from Guy's will spend some time at least on duty in England, and I, therefore, propose to deal with two or three types of case which are likely to appear at their sick parades, or in their wards, and of which they may not have had much experience in civil practice.

There can be no doubt that there are at present in this country a fair number of men suffering from chronic infection with the entamœba histolytica, the causes of which are not far to seek. The proportion of troops from Gallipoli admitted to hospital with dysentery, as everyone knows, was high; and from the observations made in the laboratories at Alexandria it appears that these cases were mostly of the amœbic variety. At the outset of the campaign this was not widely recognised, and even when it was diagnosed, the dosage of emetine was quite insufficient. This was remedied in the later months, but there was, and still is, a tendency to regard the cessation of diarrhœa after a full course of 10—12 grs. of emetine as evidence of cure of the amœbiasis.

Moreover, in addition to those treated as hospital patients there must have been a great number of troops on the Peninsula whose symptoms were never severe enough to compel them to report sick, who were yet infected.

During the past few months I have had in my wards over twenty patients who had had dysentery and were now admitted for chronic diarrhœa: in four of these cases the entamœba histolytica has been found in the stools, and in two other cases the cysts of the same or-

ganism. Of the others, a few proved not to be suffering from diarrhœa at all (always a possibility!), one was invalided out of the service as a case of ulcerative colitis after all treatment had failed, and emetine was administered to three in spite of negative reports on the stools, with relief of symptoms in one case.

The patients I have come across, who proved to have an active amœbic infection, all complained of diarrhœa, with the passage of blood and mucus. It was not the actual diarrhœa of which they complained so much as the constant provocation in the rectum to go to stool. They would then pass a loose, or in one case, a solid motion, or perhaps a little blood-streaked mucus only, but without relief from the uncomfortable sensation.

I will quote two cases to show the length of history which may have elapsed since the original infection, and the efficacy of the treatment :—

Case 1.—Pte. C., aged 33.

Previous illnesses.—Dysentery in Australia in November, 1912; was not treated, and subsequently suffered from chronic diarrhœa with the occasional passage of blood and mucus. A year later he was admitted to hospital in San Francisco and had a liver abscess opened and drained. After this he was free from symptoms for a year. . In April, 1914, while employed as a fireman in the U.S.A., he began to suffer from the diarrhœa again, and has never been free from it since. In April, 1915, joined the R.N., but was dischaged as unfit in July as a case of ulcerative colitis. Joined the army in March, 1916, and has not been out of England since.

Condition on admission.—June 20th, 1916, big, healthy-looking man; not anæmic. Passed eight motions in the first 24 hours. *Stools.*—Naked-eye examination: solid in consistence, but streaked with blood and mucus ; microscopic examination: entamœba histolytica present in fair numbers.

Ten grains of emetine hydrochloride were given subcutaneously in daily doses of 1 gr., and at the end of a week the patient was quite comfortable and having one normal motion a day. I heard from him again in September that he was still perfectly well.

In this case it will be seen that there was no record of any previous treatment with ipecacuanha. Some observers have found that there are cases of amœbiasis which are very resistant to emetine hydrochloride given subcutaneously, and a suggestion has been made that in these cases the amœbæ are contained in a pocket of the wall of the gut where they are protected by surrounding mucus from the effect of emetine circulating in the blood stream. A new preparation has, therefore, been devised—emetine-bismuth-iodide — whose advantage is that it may be given by the mouth, and results have been published showing that this method is often successful where the other mode of administration has failed. I have just had a case in which I have used this drug with success. It is given in the form of 3 capsules of 1 gr. each, taken immediately after a meal.

Case II.—Sergt. S., R.A.M.C., admitted to hospital October 14th, 1916.

Previous illnesses.—None.

History of present disease. — August, 1915, severe diarrhœa at Mudros, but carried on with duties till March, 1916, when he went into hospital at Suez; stools examined twice; no amœbæ found; had 17 injections of emetine; became rather better. June 1916, came back to England, and was in various hospitals, but had no more emetine. Since the original attack he has had four to six motions a day with an almost constant desire to defæcate, which is, however, not relieved by an action of the bowels.

Condition on admission.—General condition fair; tenderness on pressure over cæcum. *Stools.* Naked-eye examination: unformed, containing much mucus and blood. Microscopic examination: entamœba histolytica present in large numbers.

Treatment with emetine-bismuth-iodide commenced at once, 3 grains given after supper every evening until 36 grains had been given. Vomiting after first and last doses, but not for an hour or two after taking the drug.

The blood and mucus disappeared from the stools after the second dose, but the diarrhœa increased and was especially severe at night, doubtless due to the irritant action of the emetine. Diarrhœa ceased immediately on withdrawal of the drug and the patient had his first twenty-four hours free from diarrhœa for fourteen months. At the time of writing he is quite fit. Examination of the stools showed the presence of a few cysts only after three days' treatment, since when there have been no positive returns.

Inflammation of the liver is another manifestation of amœbiasis, of which I saw a few cases in the Mediterranean, in which an early diagnosis may save the patient from a very serious condition. I have had one case in my wards.

Case III.—Driver B., aged 19, admitted to hospital June 13th, 1916.

Previous illnesses.—Always healthy till he went to Suvla Bay in July, 1915.

History of present disease.—Dysentery in December, 1915. Was in hospital in Egypt and was treated with injections of emetine. Since original infection has never had more than ten days free from diarrhœa.

Condition on admission.—Looks rather anæmic; bowels open three times a day; no blood nor mucus in stool. June 16th, no amœbæ nor cysts in stool. Temperature 100°F.; complaining of general abdominal pain. Irregular pyrexia continued till June 21st, and upward increase of liver dulness was observed. No other cause could be found for the temperature. June 29th, amœbic cysts found in stools. Treatment with subcutaneous injections of emetine hydrochloride, 1 gr. daily, commenced. June 30th, enlargement upwards of right lobe of liver confirmed on X-ray examination. The liver enlargement gradually subsided and the patient left hospital at the end of August still with slight diarrhœa though nothing could be detected in the stools.

The diagnosis can only be made by examination of the stools, and here the expert protozoologist is the only satisfactory judge between the amœba histolytica and the amœba coli. In the absence of such assistance, however, the organisms may often be discovered by those less practised if attention is paid to the following points :—

1. Unless the diarrhœa is too severe it is best to give a good dose of calomel followed by a saline purge.

2. The stools should be examined as soon as possible after being passed—within half an hour.

3. A few loops full of mucus from the stool should be placed in three or four drops of normal saline—preferably at body temperature—in a watch glass.

4. A smear from this should be examined at once ; a warm stage is an advantage, but not essential.

5. The only safe criterion of the amœba is that it should exhibit amœboid movements ; these are normally active and obvious. An amœba containing ingested red cells is almost certainly histolytica. Its ectoplasm also is much clearer than that of the amœba coli.

The cysts are not easy to recognise until one has seen a few, but there have been quite good illustrations of them in the journals of the past eighteen months.

In the diagnosis of amœbic hepatitis the differential leucocyte count may be an important help, for in these cases the organisms may very often be absent from the stools. In amœbiasis, as in other protozoal diseases, there is a mononuclear reaction, and in the absence of any history of malaria an increase above the normal percentage of the large mononuclear leucocytes is a useful piece of evidence.

Treatment is specific. The subcutaneous injections are apt to cause local inflammation and tenderness, and should, therefore, be made fairly wide apart, both arms being used and the legs also if necessary. As some physicians have reported cases of damage to the myocardium, which they attribute to emetine, the patient should be kept strictly in bed during the treatment. The stools are, of course, treated in the same way as those of enteric patients.

C. P. SYMONDS,
M.R.C.P., M.R.C.S.

[We hope to publish two further articles on Diseases which have become common in Soldiers in this country in subsequent issues.—Editor, G.H.G.]

Publications Received.

Efficiency in First Aid. By N. Corbet Fletcher, M.B., M.R.C.S. Published by Bale, Sons & Danielsson, London. Price 1s. net.

This pocket manual is supplementary to the same author's "Aids to First Aid." It will be found to be useful to nurses, ambulance men, and others.

Periodicals Received.

The Prescriber, The Hospital, The Polyclinic, The British Dental Journal, New York State Journal of Medicine.

Case of Deaf-Mutism followed by Partial Amnesia.

Sergeant H., a New Zealander, was admitted under my care on September 25th, 1916. He was completely deaf and dumb, and wrote the following history of his case: "About 17th September our brigade was in support behind F—. It was very wet and the ground muddy. A shell landed on our cookhouse, killing one and wounding two others, and as the Germans were bombarding very casually (about one shell a minute), I thought there was time to get those fellows in. I had just got to them—the cookhouse was 50 yards in rear of the trenches in the open—when the enemy opened battery fire and violently bombarded the sector with large shells. My man, who had both legs broken, made progress very slow, and another shell landed within six feet of us, a piece of it hitting me in the back. I remember getting to the dressing station somehow or other, and next found myself in E— four or five days after. I could not walk, talk, or hear. I have all other faculties and can understand and think clearly. I am just beginning to walk a few steps at a time. The M.O. at the hospital in France told me it was only a matter of time and I would be all right."

On October 1st, as there was still no return of hearing or speech, he was given a little ether, and after a good deal of persuasion his speech and hearing were restored. When he regained consciousness he could hear and speak perfectly, but he believed that it was May 25th, 1915, and thought the "boys were kidding him" when they told him he was in England, as he had no recollection of having left New Zealand. The following is an abstract of an account he wrote of his doings on what he believed to be the previous day: "On May 24th, I went to church for my organ lesson at 8 p.m., and

GUY'S HOSPITAL.

Christmas Tea

— TO —

600 POOR CHILDREN

In the Out-Patient Department.

WILL YOU HELP?

by sending a Donation, however small, to

MISS SHELDON, Treasurer,

Lady Supt., Trained Nurses' Institution,

14, St. Thomas's Street, London, S.E.

ABOUT £80 HAS TO BE RAISED.

FOR the last nineteen years a Tea has been given in the Out-Patient Department on Christmas Day to 600 boys and girls, between 6 and 11 years old, who have been patients of the Hospital during the year, or are known to the District Nurses as living in wretchedly poor homes.

Besides a substantial Tea they have Christmas Trees, a Nigger Troupe of Students to entertain them, and presents to take away with them.

This year for the first time we have to appeal to a wider circle, for the War has diminished the number of our Students and our private Nursing Staff, who used to collect, and get the money without difficulty. But such a good thing as a Tea on Christmas Day for the poorest of poor children must not be allowed to drop even in these times.

SO PLEASE HELP.

"Inasmuch"

The Landon Tea Fund.

The Christmas Tea for poor children in the Borough owes its origin to the late Dr. T. W. Landon, who, when a Student, raised subscriptions for the first Tea in 1897, and in honour of his memory we appeal for the Landon Tea Fund.

The Tea is held in the Out-Patient Department, brightly decorated for the occasion, on the afternoon of Christmas Day from 2 to 4 o'clock; Nurses, Sisters, Students, and Doctors all help, and it would be impossible to find anywhere in London a happier or more delightfully noisy crowd than the 600 hungry children who enjoy a hearty meal, a visit from the "Niggers," and then a Toy, from the Christmas Tree for themselves, and a Parcel to take home to their mothers, containing ¼-lb. Tea, ½-lb. Sugar, and a Woollen Scarf or Pair of Stockings.

Gifts in Kind.

Gifts of Tea, Sugar, Toys, Scarves, and Stockings, are very welcome, and should be sent to

MISS GRIFFITH,
Out-Patient Sister,
Guy's Hospital, London, S.E.

It would greatly help if this Appeal were circulated as widely as possible, and for this purpose additional copies and directed envelopes for reply will be gladly supplied on application, or, if addresses are given, MISS SHELDON will herself undertake the postage of the Appeal.

afterwards had the treat of my life. Mr. F. played the pick of musical compositions until 11 p.m. That night will ever stand out as one of the most enjoyable of my life. . . . On Tuesday night I went to Mr. B.'s house to bid farewell to Wilf. and Rol, who are going to the war. I don't think things are so bad as to warrant my throwing up my billet as yet, and I told them so. Besides, I would miss that examination. Of course, if the worst comes to the worst I will go to the front."

His general health rapidly improved, and in a few days, with encouragement and re-education, he learnt to walk quite well. But the blank in his memory persisted, and at the beginning of November he was still unable to remember anything between May 25th, 1915, and October 1st, 1916, which appear to him to be consecutive days.

Loss of power of speech is a not uncommon sequel of the explosion of a shell in the immediate neighbourhood of a patient, and it is sometimes also a sequel of injuries due to other causes, particularly if they are associated with much shock. In addition to being unable to speak aloud, the patient cannot whisper, and in the severer cases he is unable to cough, whistle or make any sound when he laughs. He may be unable to expire with sufficient power to blow out a candle, and in rare cases he cannot put out his tongue. He may keep his mouth closed and apparently make no effort to speak; in other cases he moves his lips as if speaking, but makes not the slightest sound. He is generally able to convey his thoughts without any difficulty by writing; he is often in a highly emotional state and in severe cases may be in a constant state of terror, which is prevented from disappearing by frequent nightmares and constantly recurring mental pictures of the horrors he has passed through.

Laryngeal examinations shows that the dumbness is distinct from hysterical aphonia, as instead of the isolated paresis of the abductors, characteristic of the latter condition, complete inability to move the vocal cords is present. The dumbness is also quite distinct from aphasia, in which articulate sounds can be made without difficulty and certain words are often reiterated. Moreover, the patient understands what he reads and what is said to him, and he can express himself perfectly well in writing; it is clear, therefore, that the mutism must be due to incapacity of the cortical nerve centres which control phonation and the production of sounds. That this incapacity is functional is proved by the fact that the patient may call out in his dreams, although he is completely mute when awake.

To have one's breath "taken away with surprise" and "to be speechless with rage" express the familiar effects of emotions on respiration and on speech; the excessive shock and the frequently associated emotions of excitement and fear, when a man is blown up by a high-explosive shell in the course of a battle, give rise to similar phenomena but in an exaggerated degree, and the patient on recovering consciousness may become obsessed with the idea that the speechlessness is permanent—the mutism being thus maintained by a process of auto-suggestion.

The dumbness is often associated with deafness, but recovery from the latter or less frequently from the former may rapidly occur, so that the other condition remains alone. Complete mutism often lasts only a few days, after which it may disappear entirely or give place to some form of stammering or less frequently to simple aphonia, when the patient is able to whisper but not to speak aloud. Sooner or later recovery always takes place. It may be spontaneous and occur suddenly or gradually without treatment or as a result of encourage-

ment, but more often speech returns suddenly as a result of direct suggestion, which overcomes the fixed idea of mutism, or of some sudden emotion, which breaks down the subconscious inhibition of speech by surprising it when the patient is off his guard, with his mind for the moment not fixed on his dumbness. Thus speech may return as a result of crying out when in pain or in a moment of excitement, whilst watching a boxing or football match or during a Zeppelin raid, or a mute may suddenly find himself joining in a familiar chorus. It may also return after a nightmare in which the patient calls out, though more often this is not followed by recovery.

A man dreamt that he was blown up by a trench mortar and shouted for help. He woke to find himself speaking; he continued to do so, and did not go to sleep again for fear he might lose his speech. I saw a man who was sleeping when his parents came to visit him a fortnight after he had become dumb as a result of shell-shock. They woke him up and he at once said, "Hullo, mother!" Another man recovered after being given a cold douche just as he was getting out of a hot bath, and yet another after I had tickled his larynx with a catheter, which I had told him would restore his voice.

In resistent cases hypnotism is very effective, but it is useless if the patient is completely deaf. The administration of ether accompanied by active suggestion should then be tried, but this is not without danger, as in the above case and in that described by me in the GAZETTE of September 9th, partial amnesia was produced at the same time as speech and hearing returned. Fortunately, however, the memory remained perfectly normal except for the period of sixteen days in the first and sixteen months in the second. The ether acts much in the same way as alcohol; thus a dumb soldier got drunk whilst out of hospital on leave; he "found his voice," and for two days talked and sang without intermission.

A. F. H.

Two Interesting Cases of Pregnancy.

CASE 1.—*Pregnancy complicated by Acute Appendicitis and Intestinal Obstruction.*

Mrs. C., aged 30. Seven months pregnant; one child, aged 2. At the beginning of April, 1910, her illness commenced with acute abdominal pain, vomiting and absolute constipation. I was asked to see her on the second day of the illness, and she now had intense pain and tenderness in the right iliac fossa and in the right loin. Pulse 130, temperature 101° F. No action of the bowels and no passage of flatus with repeated turpentine enemata. Thus we had a definite localised appendicitis and intestinal obstruction associated with a pregnancy of seven months' duration.

The question arose as to the best plan of procedure to adopt. We decided first to empty the uterus. After delivery, which was accomplished in a few hours, that which we hoped came to pass: the temperature subsided and the vomiting ceased, and the bowels acted spontaneously the following day. Two weeks later there was another sudden rise of temperature to 102·6° F., pulse 124, and both rising. I opened the abdomen forthwith and evacuated a retro-cæcal appendix abscess, but did not remove the appendix. She is now in robust health, and has always since refused to entertain the idea of appendicectomy.

The method employed in dealing with this case may be open to criticism, but my reasons for adopting the above procedure were as follows:—

The obstruction was almost certainly due to adhesions around the lower end of the small intestine, aggravated by the increasing enlargement of the uterus. If an open operation was performed for the relief of the condition, con-

siderable difficulty might have been experienced, owing to the limitation of working space by the big uterus. Even had this been possible, one of two alternatives must follow :—

1. The pregnancy proceed to full term with increasing strain on a new abdominal wound.

2. Premature induction of labour at the seven months as the result of the abdominal section. In this case, during the labour, there must be still more tension on the stitches and tendency to break down the wound, especially in view of the fact that it might have been advisable to drain it temporarily. In this latter contingency, also, there would arise the potential risk of a puerperal infection from the septic discharge from a tube in the lower abdomen.

Lastly, the patient already had one living child, and as regards the existing pregnancy, the life of the mother was naturally the first consideration.

Present condition, November, 1916.—This patient has had no further recurrence of appendicitis until last month, when she returned again to the hospital in an acute attack. Many adhesions were found and the appendix was removed with difficulty. Patient has got very stout since her previous admission. Recovery uninterrupted.

CASE 2.—*Pregnancy complicated by Strangulated Ovarian Cyst.*

This is another complication of pregnancy.

Mrs. M., aged 25. *Four months pregnant* for the first time. On April 30th, 1914, she retired to bed with increasing abdominal pain and vomiting, which lasted for about two hours; the pain gradually subsided, but the attacks of vomiting continued though with less frequency. She was first seen on May 2nd, when her temperature was 100·8° F., and pulse 120. There was then pain and tenderness in the right iliac fossa and a soft swelling was observed. She had been constipated for four days, and not until repeated enemata had been given could the bowels be induced to act.

On May 4th the temperature rose to 101° F. and pulse to 130. Later on the same day I was asked to see her, and her pulse rate was still rising, though this may have been in part due to apprehension. The abdomen was asymmetrical, but the tumour was now considerably larger and occupied the left side of the abdomen. It was tender and painful, but not tense, extending from the pelvis to the costal margin. The patient had to be moved some distance to the hospital, and this could not be done until the following day (May 5th). Very shortly after admission both pulse and temperature began to drop, so she was kept under observation for three days, at the end of which time the temperature was normal and the pulse 110. The periodic vomiting (of which, by the way, there had been none at the commencement of the pregnancy) persisted, as also did the obstinate constipation. The abdomen was opened on May 9th, and a large and completely strangulated cyst of the *right* ovary was found, which in the course of its strangulation had rotated to the left side. There were patches of commencing gangrene in its walls and some local peritonitis with plastic adhesions to the pelvic colon. The tumour was removed without difficulty, and the pregnancy is proceeding without disturbance.

The problem for solution was the interesting fall of both temperature and pulse with the local lesion within the abdomen most obviously going from bad to worse.

Patient went on to full term and had a normal labour.

NORMAN FLOWER,
M.A., M.B., B.Ch. Oxon.
Assistant Surgeon, Yeovil Hospital.

Case of Kharsivan Poisoning

PATIENT, a woman aged 25, sustained a compound fracture of her tibia and fibula last March. She was admitted to the hospital under Sir Arbuthnot Lane with the wounds still septic. A month later she developed a secondary rash and gave a positive Wassermann. On the 8th July, 1916, an attempt to give Kharsivan was made, but only a few ounces were injected. Three weeks later ·6 grms. in 300 c.c. of saline were administered intravenously. For the next 40 hours her temperature ranged between 99 and 100; patient seemed quite normal except for loss of appetite and having vomited twice. At about 2 p.m., 44 hours after administration, the patient became hysterical, her pupils were widely dilated, she complained of a headache and a sense of impending disaster. An I.M.H. one-sixth gr. was given and the patient quietened down until 6 p.m. when she became restless and dyspnœic, culminating in an epileptiform fit at 6.30, which lasted about one minute. For the next six hours the patient had similar fits, each lasting a minute, the interval between them decreasing from 35 to 5 minutes, having in all sixteen.

During this time patient was unconscious; her pupils were dilated, but her corneal reflexes were present; her face was congested, but there was no œdema; much blood-stained mucus accumulated in the pharynx. No vomiting and no diarrhœa. A catheter was passed and 14 ounces of urine were obtained of low specific gravity and containing albumen. The pulse rose quickly to 160 and remained in this region until 12 o'clock. Half-hourly temperatures taken in the axilla showed a steady rise from normal at 6 to 102 at 12. The respirations remained normal in rate, but became stertorous and later markedly Cheyne-Stokes.

From 12 a.m. the patient's condition became worse. She sank more deeply into a state of coma. The Cheyne-Stokes respiration, which had been so marked gave place to slow stertorous breathing. The corneal reflexes disappeared, the pulse fell to about 140 and became weak and irregular. The temperature gradually rose to 104°, and she died at 5 a.m., $10\frac{1}{2}$ hours after the first fit.

From the onset at 6.30 the patient was infused into the axilla with 4 pints of saline containing 1—40,000 adrenalin. Atropine was injected and 2 dr. paraldehyde were given rectally and later an I.M.H. $\frac{1}{4}$ gr. During the fits oxygen was given.

The post-mortem showed few definite changes. There was much mucus in the bronchioles and slight softening in the base of the brain, but no congestion of the cortex. A. G. M.

Honours.

Military Cross.

Temporary 2nd Lieutenant Sidney William Bevis, R.F.A., for conspicuous gallantry and devotion to duty. When telephone and visual communication was impossible and his orderlies were absent on duty, he thrice carried messages from the front line under intensely heavy shell fire.

Mentioned in Despatches.

In a despatch from General Sir Reginald Wingate, Sirdar and Governor-General of the Soudan, dealing with military operations in that country, the name of Major R. G. Anderson was mentioned.

The name of Staff-Surgeon A. T. Rivers, R.N., is to be added to the despatches detailed from Sir Ian Hamilton, dated December 11th, 1915.

Roll of Honour.

Died of Wounds.

Capt. M. J. Rees, R.A.M.C.

Killed in Action.

Capt. N. P. Shepherd-Turneham, L.D.S., Princess of Wales' Own Yorkshire Regiment.

Second Lieut. W. G. Hollands, Royal Fusiliers.

Address on "The Meaning of the National Mission."

By MAURICE CRAIG.

The National Mission has many purposes, but the outstanding feature is a call to men and women of all ranks to turn to account this European upheaval by taking stock of themselves, as units of a Christian country, to see if all is well with them and the community in which they live, and to analyse their shortcomings, and to endeavour to advance the cause of Christianity and the civilisation of the world.

This great conflict, including as it does many of the most cultured nations of the world, has brought to every side of national life the touchstone of reality. It is testing everything and laying bare the weakness and the strength in every department. For the moment it has removed all veneer and superficiality and is driving us back to fundamentals. The Prime Minister has spoken of the War as having at its root a conflict of spiritual principles. It is with these spiritual principles that we are concerned to night.

There are only two working conceptions which we can hold of the life of mankind. The physical or materialistic principle connotes that "might," "power" and "force" are the dominant elements. In its crudest form it demands the survival of the fittest. Above this you can construct a purely ethical code. Huxley writes: "The practice of that which is ethically best, what we call goodness or virtue, involves a course of conduct which is in all respects opposed to that which leads to success in the cosmic struggle for existence. In the place of ruthless self-assertion, it demands self-restraint, in place of thrusting aside or treading down all competitors, it requires that the individual shall not merely respect but help his fellows; its influence is directed not so much to to the survival of the fittest as to the fitting of as many as possible to survive. It repudiates the gladiatoral theory of existence. It demands that each man who enters into the enjoyment of a policy shall be mindful of his debt to those who have laboriously constructed it, and shall take heed that no act of his weakens the fabric in which he has been permitted to live. Laws and moral precepts are directed to the end of curbing the cosmic process and reminding the individual of his duty to the community, to the protection and influence of which he owes, if not existence, at least the life of something better than a brutal savage."

Such a high ethical code demands unity of aim in a nation, direction of purpose and order to be given to the commercial, political, industrial and educational methods of the whole community. It demands the active responsibility of each citizen to know himself to be a part of and a worker with the whole body of the nation.

Now all this seems good, and undoubtedly is good, for it is beneficial both to the individual and the common weal, provided that the motive which formulates and drives it is faultless and all-embracing.

But it is here—the motive—where the materialist discovers his insurmountable difficulty. The rulers of the Central Powers, and more especially Germany, organised their national life in a way probably more thorough than has ever been done by any people before, but what was the motive force behind it all? It was the advance of the German nation until it should become the supreme power in the world. Health and education, social and political aims were all advanced for the same end, viz., a strong virile race prepared to endure much so long as the national aspirations were attained. The present conflict, and what we hope and believe will be the result, should for all time give food for reflection to the materialist.

The materialist calls science to his aid, but only to find that his difficulties increase as his scientific investigation goes on. He is met at the outset with the fact that the purely materialistic hypothesis utterly fails to render an adequate interpretation of the phenomena of life. Balfour, in his Presidential Address to the British Association at Cambridge in 1904, says: "Extend the boundaries of knowledge as you may; draw how you will the picture of the universe; reduce its infinite variety to the modes of a single space-filling ether; retrace its history to the birth of existing atoms; show how under the pressure of gravitation they become cencentrated into nebulæ, into suns, and all the host of heaven; how, at least in one small planet, they combined to form organic compounds; how organic compounds became living things; how living things, developing along many different lines, gave birth at last to one superior race; how from this race arose, after many ages, a learned handful, who looked round on the world which thus blindly brought them into being, and judged it, and knew it for what it was:—perform, I say, all this, and, though you may indeed have attained to science, *in no wise will you have attained to a self-sufficing system of beliefs.* One thing at least will remain, of which this long-drawn sequence of causes and effects gives no satisfying explanation; and that is knowledge itself."

To me the greatest objection to materialism, even in its most highly altruistic form, is that it does not provide me with anything like a supreme end to the attainment of which I should direct my aims. The questions "whence I came" and "whither I go" remain unanswered, and so I turn elsewhere to see if I can find anything more satisfying.

The spiritual principle of which the Christian religion is the supreme witness and exponent holds that there are supreme and eternal laws for individual and social action, which are the principles of the mind and will of God, which are unalterable and eternally true and which men and nations can only live truly by obeying and co-operating with.

This spiritual religion embraces all the highest ethical codes; it preaches goodness and righteousness, resistance of evil, love for each and all, and living for the good of all.

When you bid the materialist look round the universe and direct his attention in turn to the animal and vegetable kingdoms, to the sea, to the constellations by night, to life and death, and you ask him what is the meaning of it all, he can only generalise on the laws of nature, but omitting to account for the origin and purpose of nature.

Turn and ask the same question of the Christian exponent, and he will tell you that all that is in the world means Christ, for it is in Him "we live and move and have our being."

At first it would seem that religion and science were in opposition, and in so far as faith is the antithesis of fact, there might seem to be some support for this view. On the other hand, the further we advance in our quest after truth, the more certain we become that science and religion are not enemies. Science embraces all those methods by which we endeavour to learn the forces of nature. Clearly, then, science should be the servant of religion, and it is the duty of every scientist to use his knowledge to discover all that is possible about religion and the spiritual issues of life, for religion is the climax of that evolutionary process which it is the business of science to trace out. It seems to me incredible that any man, whether he is a believer in the story of the New Testament or not, can wittingly pass by unheeded the problem of why he is born into this world and whither he is wending. Mandell Creighton, a former Bishop of London, once said:—"There is nothing so hopeless as the torpor of indifference." I cannot imagine how any thinking man can be indifferent to this problem if he ever stops to think and once appreciates the importance of it—the trouble is that so many men do not stop to think. Thus we arrive at the questions which the National Mission asks each one of us to answer. Are you content with things as they are? Do you arraign yourself on the side of materialism or as a member of the Christian Church? If it is the latter, do you fulfil the obligations which your belief imposes upon you? It may be that you have never squarely faced this problem. We have a habit in life to repress all thoughts which give rise to a conflict in our minds, and even when, from time to time, we wonder whether we are right in so doing, we end by rationalising our action on the grounds that better men than ourselves have tried and failed to discover the truth on these matters. Others may have spent time and thought on this vital problem, and although they feel that there may be something in the story of two thousand years ago, yet it seems so far removed from them that they cannot incorporate it into their life. They leave it, hoping that some day they may see more clearly what it all means. There is yet another aspect which it is impossible to ignore. Some persons consider it as effeminate or not manly to be what they choose to call "religious." How has the idea developed? To-day as in the past many of the deepest thinkers, scientific or otherwise, have decided that idealism is the only possible explanation of life, but for the moment and for the sake of argument, let me accept the hypothesis that it is otherwise. It is true that as a whole women are more religious than men, and perhaps it is equally true that many physically weak individuals devote more time to the study of religious subjects and are in consequence more enlightened and greater believers in the Christian faith. But what if this is one of the compensations for their frailties in other directions, or in the case of women there may be another explanation. Nature—and, as I have already told you, when I speak of nature I mean the workings of natural laws for and towards one supreme end—I repeat, nature has imposed largely upon women the duty of bringing up their children, and I cannot help but think that their natural tendency to goodness is not an accident but a purpose of far-reaching importance. To return to my statement that there are some persons who regard it as a sign of weakness or something to be ashamed of to be too definitely associated with religion. As I have said, the error may arise owing to the class of person who is believed to be the common example of a Christian life. On the other hand, it may be owing to the fear of what a man believes to be required of a true Christian. This, I think, is important, for no doubt many men feel that to declare oneself as religious is to be always talking and behaving in the manner that they have preconceived that a declared Christian should behave. That you are a Christian does not necessarily mean that you have to change your temperament. The silent man need not become loquacious, and the shy and retiring one is not called upon to become a preacher. Each man in his own manner and by his own gift can declare himself. It is not always what a man says that declares his thoughts; it may be his actions that declare the purpose which is directing his life. On the other hand, a Christian cannot be a coward, and although he may not be called upon to speak of his innermost thoughts and beliefs, he must not be afraid to speak if it is his duty so to do; otherwise some day he may remember his failure and, like Peter of old, weep bitterly.

Of one thing I am certain, that it cannot be the subject that men are afraid of, for such a thought is impossible. It must be some ideas which, in the course of time, have become associated with it. Throughout all ages it has been necessary from time to time to free subjects from tradition and superstition which may have sprung up around them; medicine and surgery, as you are aware, were no exceptions, and, as I have so often told you, psychological medicine is only now beginning to free itself from the shackles of associated error which so long surrounded it. Therefore it is our duty to treat religious subjects to the same sifting and endeavour to get down to the fundamental truths upon which it is based, for it is only by so doing that

we can form a fair judgment. Seek out where the errors of modern thought may lie, and as I have already suggested, analyse the three factors which are essential in coming to a proper judgment—and these are (1) *yourself*, with all your preconceived ideas, your prejudices, your tendency to accept superficialities and your natural diffidence; (2) the *subject itself*, which at times tends to become obscured by the manner in which it is presented to you; (3) and finally there is the *adjusting of the subject to yourself*. so that it is no longer an irksome adjunct to an already over-weighted life, but a part of that very life itself.

There is a psychological aspect that may help some of you. Some persons expect to acquire too rapid an insight into religious matters and consequently fail, but the same is true of many problems of daily life. If we form a judgment of what we consider to be our ideal on any subject, and we fail to reach it, the tendency is to cast it aside and seek happiness or interest in something else. This is true of our attainments, our ability for drawing. painting, music; our skill at games. The thought that he cannot reach his ideal may even sour a man's professional life. How often do I get men and women coming to me with the story that they are engaged to be married, and that someone has told them that no person ought to marry until he or she has reached such a degree of affection that he feels that life without the partner of his choice is impossible. A truly terrible test to place before all persons who are contemplating marriage. And no doubt if such an answer had always to be given, many conscientious persons would fail to satisfy themselves that it was right to marry. Clearly the cause of doubt and failure in these instances is that some persons expect to reach their ideals too rapidly instead of being satisfied gradually to attain them. Whatever subject we wish to acquire a knowledge about, it is necessary to devote time to its study. Now there is no difference between physical and spiritual things. Many people fail to attain an insight into religious subjects because they have never really tried to understand them. It is a truism to say that as we study a subject so our knowledge about it grows, but what I wish to point out is, that, though at first it may be almost impossible to follow its meaning or to understand even the language of it, yet later everything becomes clear.

The National Mission is a challenge to the nation to think, and a call to the individual to study and work at his religious beliefs for his own good and through him for the good of the race. This war has brought this life and the life beyond very closely in touch. Hundreds of thousands of men are passing from our physical view, not from disease or decay, but in the heyday of life. Can all this be for nothing but some evanescent temporal reason, or is it part of some great scheme, the climax of which is in a spiritual world where evil is unknown and righteousness reigns supreme. The range of science is a narrow one; it is certain that there is a vast physical universe of which we have no direct cognisance. The soldier in the trenches during the utter loneliness of his vigil will tell you that such a condition makes him realise the nearness of the spiritual world. He at least can appreciate that there is something behind physical force. Now that which we can sense in moments of strain can be perceived by calm introspection and with careful study. There are many types of men; some are swayed by their emotions, and during their life they may have had moments when they have been so stirred by some incident or discourse as to be convinced that there was a spiritual world beyond this present life. There is a grave danger here, for merely to have one's feelings roused may be a transitory state. Pleasure and pain, though acute whilst they last, are easily forgotten. If you doubt this, try for yourselves and recall pleasurable or painful emotions. Another type of man is he who experiences at first no enthusiasm from the incident which sets his emotional brother aglow; nevertheless the occurrence, whatever it may be, sets him thinking, and as he enquires more and more into the matter, the pleasurable sensation and feeling of at-homeness gradually develop. Doubt and difficulties every thinker must have, but what is doubt but an oscillation between two beliefs. It is better to doubt than never to think, for at least in this state we encourage in ourselves a desire to know all we can about the subject regarding which we withhold judgment. In other words a feeling of certainty may be a rapidly formed judgment which is strongly toned by emotion, or it may be the outcome of gradual development. Our mental life is never stationary the thoughts which go to form our ego at one moment are not the thoughts of the next. As years pass on we must be either reaching forward to some higher ideal or we must be becoming increasingly materialistic. In our professional life as each year passes we take stock of our progress, and we ask ourselves "how are things going?" The National Mission reminds us that it is not only our professional life of which we ought to take stock, but to ask ourselves whether we are equally advancing towards our religious ideals. There is no such state as a Church at ease, and in that the Church is composed of Christian units, a Christian man cannot remain idle; such would be the very antithesis of the Prototype whom it is his duty to follow.

In this temporal world caste and class separate individuals from each other, but the Christian Church knows of no such distinctions—it is one large brotherhood. Therefore, the second great question you have to answer is—"Is all well with your fellow men?" Christians are apt to leave to others the work they should be doing themselves. There is no saying from the Bible that one reads more frequently during these times than the following:—"Greater love hath no man than this, that a man lay down his life for his friends." This is the Christian ideal of brotherhood carried to its highest pitch, and although it is denied to many of us to attain to it, yet the obligation is there and we must not shrink from it.

The Christian Church has passed through varying periods since its foundation. There have been several phases when the units which composed it were all working each in his separate sphere for the Church's advancement. Between these phases there were other times when all appeared dead, and the enthusiasm of the past only seemed to accentuate the gloom of the moment. For some decades just past, materialism has been again in the ascendant, and although many of us would not like to be classed with those who had no hope, yet the charge is only too true that we have done little or nothing to further the spiritual welfare of ourselves or mankind. A crisis such as the world has never known has come upon us, and is affecting almost every aspect of our family and national life. Now, if history is to be trusted, if the experience of the past can be used to throw any light upon coming events, I, for one, venture to think that materialism is once more to be superseded by a spiritual renaissance. When this takes place it will no longer be the few who struggle to keep the spiritual issues before the people, but the people themselves will be doing their share. The rapid advance of secular education during the nineteenth century seemed to swamp other thoughts and natural science seemed to sweep all before it, but as I have already pointed out, great modern thinkers more and more appreciate that as natural science grows it leans more, not less, upon an idealistic interpretation of the universe.

To repeat, the National Mission asks of each man: What is your vision? What is the underlying principle of your life? The medical student who acquires a knowledge of his profession in the hope of some day being a successful physician or surgeon or that he may dedicate his life to humanity has an ideal and purpose in life, but if this is all, believe me, his life lacks the force of that of the man whose life is based upon the Gospels, and the teaching of Christ.

New X-Ray Room.

THE X-Ray Room adjoining Astley Cooper Ward will be ready for use on Monday, the 6th instant.

The apparatus will be available for taking radiograms of cases from the Accident and Surgical Wards every morning, and the plates will usually be delivered in the afternoon,

(Signed) E. C. PERRY,
4th November, 1916. Superintendent.

Gazette Special Pathologist.

W. E. S. C., BALHAM.—This sputum contains mucopus associated with a moderate number of tubercle bacilli.

Letters from Old Guy's Men on Active Service.

Persian Gulf,
September 27th, 1916.

Our journey is drawing to an end, and we are expecting to land to-morrow. We don't know yet what our job is going to be, but I expect we shall all get orders for different things quite soon when we're landed. We have had a very good time coming out here on three different hospital ships. The last has been the most comfortable, so it will be rather a change from good beds, good food, and plenty of iced drinks, to the sun without much shade and army rations. About fifty of us started together, and except for one man who was nearly better when we left Bombay, we have all managed to keep fairly fit, but even on board, with good water and cooking, colic and diarrhœa have been unpleasantly common. We have been inoculated against cholera as well as the combined typhoid. The authorities think it is a good thing, although not nearly as good as the other. Anyhow, it does not upset one at all like the typhoid one.

We had a week at Alexandria in camp, practically on the sea shore. It was very hot, but fairly dry and qulte pleasant. The Red Sea and Bombay were hot and moist, and most unpleasant. This seems to be between the two, and everyone says that up-country the climate is quite good, though Basra seems to be pretty beastly. Bombay was quite an attractive place, though it tempted one to spend a good deal of money. We were just staying at a hotel on our own, so had a good deal of freedom. Jones and Glover had been there, but have just gone up to Mesopotamia, so, perhaps, I may come across them. Hirsch is still in Bombay, but I did not see him.

We pass a hospital ship nearly every day now, so there ought to be plenty of medical supplies available. I have met a good many people who have come back from Mesopotamia and they have fairly different accounts, but everything seems to be quiet now. The cooler weather begins next month, I don't know whether this will mean any change. Anyhow, I expect things will wait for the arrival of the new C.-in-C. in India. I am very glad he is coming out. We get very little news here. Of course we have had no letters at all yet, and though we generally hear the official news this is difficult to follow without maps, and the Indian and Egyptian papers we have seen were very dull. What is annoying is always finding new bundles of papers, and then finding that they left England at the same time as you did.—Yours. MAURICE CAMPBELL.

42 Casualty Clearing Station,
B.E.F., France,
2nd November, 1916.

As promised I am writing a few lines to tell you, after having been in charge of the Surgical Ward at the Palais des Regalies Hospital branch of No. 2 General, Havre,

for a week, I was suddenly ordered to come to the above address, which is about — miles behind the line. At present this front is quiet, so cases for admittance are below the average.

My C.O. is a charming Irishman, Colonel Ormsby by name, and the surgical specialist is an old Guy's man, called Captain Mumford. There are two other men besides myself and a dental surgeon: three others are away temporarily on a busier part of the line. The whole hospital is in huts and very well arranged, and we billet out in the village. The latter is my greatest difficulty as my servant, who is quite a good chap, stammers badly, and his French vocabulary is worse than mine, if that could be possible.

An old Guy's man, Colonel Hewetson, visited us yesterday for lunch, and I hear Young is in the district as bacteriologist, and was actually attached here.

We are well guarded by aeroplanes, so the Bosche hardly ever comes over us, and it is simply wonderful to see the manœuvring the airmen do in practising out here; they are marvellous.

* * * * * *

Yours very sincerely,
REGINALD CURLE.

British Prisoners of War Book Scheme (Educational).

UNDER the direction of Alfred T. Davis. J.P., Board of Education (Chairman); George E. Baker (Board of Trade); Major A. Y. G. Campbell, C.I.E.; Rear-Admiral J. F. Parry, C.B,; the Countess of Bective; David Daviss, M.P.; C. T. Hagberg Wright, LL.D.

Object:—To provide British Prisoners of War interned in enemy or neutral countries with educational books.

The letter printed below has been received by the Wills Library Committee:—

Board of Education,
Whitehall, S.W.,
October 10th, 1916.

Dear Sir,—In connection with the working of the above scheme requests have been received from some British Prisoners of War interned abroad, for the books mentioned.

It would be a great help to the Committee if you could assist them to obtain one or two copies (which need not necessarily be new) for transmission to men interned abroad. The Committee's resources do not permit of their purchasing the many thousands of books for which they are receiving applications, so that they are to a great extent dependent upon the gifts of a generous public.—Yours faithfully,

(Signed) ALFRED T. DAVIS,
Chairman.

BOOKS DESIRED.

Diseases of the Eye (May & Worth).
*Diseases of the Skin (Norman Walker).
*Diseases of the Ear, Nose and Throat (Fraser & Dickson).
*French and English Medical Directory.
Conferences sur Physiologie, Mécanique et Hygiene appliqué aux Exercises Physique (Savorein).
Massage.
British Pharmacopœia (last issue).
Psychological Medicine (M. Craig).
Heart Disease (Mackenzie).
General Bacteriology (Frost & Campbell),
Heart Beat (Lewis).
Clinical Methods (Hutchison & Rainey).
*Sanity and Insanity (Mercier).
Criminal Responsibility (Oppenheimer).
Criminology (Lombroso) in French.

* Particularly desired.

If any of our readers have any of these books which they are willing to give in this extremely good cause, they should be sent to the Librarian, the Wills Library, Guy's Hospital, S.E. They will then be forwarded by him, and their receipt duly acknowledged.

Appointments.

Royal Army Medical Corps.

The following appointments have been made:—

To be temporary Captains:—H. Davies-Colley F.R.C.S., R. P. Marshall, A. M. Webber, B. H. Palmer, E. J. Maxwell, M.B., A. C. Dickson.

To be temporary Lieutenants:—H, S. Jones, R. Franklin, R. C. H. Francis, M.D., J. D. Pearson, A. P. Piggott, J. F. H. Stallman, W. J. Smyth.

Capt. (Temporary Major) E. D. R. Jacob and Capt. E. E. Solomon, Hampshire R.G.A. (T.) are seconded for Anti-Aircraft duties.

Indian Medical Service.

To be Lieutenant permanently:—C. W. W. Baxter.

Dental Commissions.

Ernest Charles Rycroft has been appointed Army Dental Surgeon with rank of temporary lieutenant.

Temporary Lieutenants to be temporary Captains:—R. M. King, E. Smith, G. F. Charles.

E. P. Hudson, L.D.S., to be temporary Lieut., R.F.A.

Civil.

Mr. A. D. Marston has been appointed Obstetric Assistant and Registrar at Guy's Hospital for a period of six months from November 1st, 1916.

F. G. L. Scott, M.R.C.S., L.R.C.P., has been appointed Assistant Medical Officer of Bermondsey Parish Infirmary.

Notices.

The National Mission.

It has been arranged to have three services in the Chapel on Tuesdays, November 28th, December 5th and December 12th, at 8.15 p.m., in connection with the Mission. The November Mission Meeting will be cancelled. All are invited to attend, whether students or members of the nursing staff.

Astley Cooper Prize.

The next Triennial Prize of Three Hundred Pounds under the will of the late Sir Astley Cooper, Bart., will be awarded to the author of the best Essay or Treatise on "Gunshot Wounds of the Lungs and Pleura."

The competition is open to everyone except the Staffs of Guy's and St. Thomas's Hospitals and their relations; but the essay must not be the production of two or more authors. Candidates are informed that their essays, written in English, must be sent to Guy's Hospital, addressed to the Physicians and Surgeons, on or before January 1st, 1919. Each essay or treatise must be distinguished by a motto, and be accompanied by a sealed envelope containing the name and address of the writer; none of the envelopes will be opened except that which accompanies the successful treatise.

The Trustees will entertain the question of the publication of the successful essay in the "Guy's Hospital Reports." This will not, of itself, preclude the successful competitor from publishing his essay elsewhere upon obtaining permission.

For particulars regarding the other conditions to be complied with, application should be made to C. H. Fagge, M.S., Guy's Hospital, London, S.E.

Change of Address.

Capt. F. R. Wallis, R.A.M.C., from 3rd Southern General Hospital, Oxford, to 49th Casualty Clearing Station, B.E.F., France.

Capt. T. W. Sheldon, 139th Field Ambulance, B.E.F., France.

Lieut. R. Curle, R.A.M.C., 42nd Casualty Clearing Statian, B.E.F., France.

Capt. E. F. Reeve, R.A.M.C., "Leoni," Dacre's Road, Forest Hill, S.E.

R. S. Mutch, M.D., from Hamilton Lodge, Hanger Hill, Ealing, to "Lydstep," Sheen Road, Richmond.

Lieut. H. P. Aubrey, R.A.M.C., from 93rd Field Ambulance, B.E.F., to Headquarters, 42nd Group Heavy Artillery, B.E.F.

Capt. W. T. Chaning Pearce, attached to the 18th King's Liverpool, B.E.F.

Capt. R. C. Matson, R.A.M.C., to 78, Victoria Road Aldershot.

Capt. J. E. Venables, R.A.M.C., to Military Hospital, Swanage.

Second Lieut. J. H. E. Winston, 5th Yorks. Regiment, B.E.F., France.

Pass List.

Royal Colleges of the Physicians of London and Surgeons of England.

At the Examinations held recently the following condidates were approved in the undermentioned subjects:—

Medicine.—J. A. M. Alcock, J. A. Berry, H. W. Eddison, J. E. E. Robillard, H. E. Bamber, G. W. Heckels, T, L. Heath, G. E. L. Simons, *H. Sterne-Howitt, O. St. L. Campion, S. Vidot, J. F. C. Braine, H. Johnson, K. M. C. Woodruff, E. A. Leviseur, A. W. A. Davies.

Surgery.—A. W. A. Davies, J. A. Berry, J. E. E. de Robillard, H. E. Bamber, G. W. Heckels, T. L. Heath, G. E. L. Simons, *H Sterne-Howitt, F. N. Sidebotham, C. L, Odam, N. H. S. Maelzer, A. B. Cocker, M. C, Joynt.

Midwifery.—J. A. Berry, H. E. Bamber, G. W. Heckels, O. St. L. Campion, S. Vidôt, W. S. Buer, H. D. Aspergis, L. Gill, A. H. H. Barlow, H. N. Pritchett, W. J. Walters, F. R. Leblanc, J. C. C. Howe, J. Kyle.

*Owing to an error in the list of successful candidates received from the Royal College of Surgeons, we regret that Mr. H. Sterne-Howitt's name was omitted from those mentioned, who were approved in Midwifery last July.

Papers by Guy's Men.

Charles H. Budd, L.D.S. Eng.: Some technical details in the treatment of jaw fractures.—*British Dental Journal*, November 1st, 1916.

C. D. Wallis, L.D.S. Eng.: Dental inspection and treatment of school children in the County of West Sussex.—*The Dental Record.* November, 1916.

Capt. J. S. Allen, R.A.M.C.: Experiences of twelve months' X-ray work in France.—*Journal of the R.A.M.C.*, October, 1916,

Major L. Jones, R.A.M.C.: Gunshot wound of pericardium and heart: pneumo-hæmopericarditis: operation: recovery.—*Ibid.*

Major Graham Simpson, R.A.M.C.: Two cases of laminectomy.—*The Practitioner*, November, 1916.

Birth.

NEVILLE-COX.—On the 3rd November, at 21, Cornwall Gardens, Brighton, the wife of Lieut. A. Neville-Cox, of a son.

Deaths.

REES.—Died of wounds on October 30th, Capt. Morgan James Rees, M.D. Lond., of the Local Government Board. Aged 41.

J. J. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

ONE of the most unpleasant features of the war during the past fortnight has been the loss of two of our largest hospital ships, the *Britannic* and the *Braemar Castle*. It is not apparently absolutely certain whether they were torpedoed or mined. An official Berlin statement denies that the *Britannic* was torpedoed by a German submarine, but some of the German press seem to admit that a submarine was responsible, and attempt to justify it on the grounds that the *Britannic* was engaged in carrying men or munitions for Salonica. The question will probably not be finally decided for some time, but if it should be proved that these vessels were deliberately torpedoed, it would be a crime far more monstrous than any of the other atrocities of this terrible war. The happy fact that the number of casualties is small does not in the least diminish its atrocious character.

The *Britannic* was the largest ship in the world with the exception of two German liners. It had only recently sailed for the Mediterranean, and we fear its loss may throw a severe strain on our medical organisation in the near East. We hope that the loss of these two vessels is not the beginning of a regular submarine warfare on hospital ships. If it is, the natural relief which the wounded feel when on their way to "Blighty" will be replaced by a constant anxiety. The nerves of those who have been wounded are not of the strongest, and if every hospital ship is liable to be sunk, either with or without warning, it will add materially to the terrors of being wounded. Up till the present, hospital ships have been fairly safe in the Mediterranean. During the Gallipoli campaign they were allowed to lie close to the Peninsula wtihout being molested by Turkish shells or torpedoes. We can only hope that the loss of the *Britannic* and the *Braemar Castle* will prove to have been due to mines.

A GREAT deal has been written lately in some of the weekly and daily papers, of which we have least reason to be proud, on the subject of Field Punishment No. 1, or, as they term it, crucifixion. Among other attacks made on this system of punishment in our army abroad is that it is detrimental to the health of those men who undergo it. As, perhaps, all our readers may not understand exactly the nature of Field Punishment, we will explain it. A soldier undergoing this punishment sleeps in the guard-room instead of his billet. In practice there is usually little to choose in comfort between the two. He does any fatigue work that may be

needed, such as scraping roads, etc. While not working he may be handcuffed. For two hours a day, on not more than three days out of four, he is tied up to some stationary object such as a cart wheel, fence, or tree. He may not be tied up in any place where there is danger from enemy shells. Further, he is not tied up with arms or legs extended as suggested by the term crucifixion. He is visited daily by the Orderly Officer to whom he can submit any complaint, and if he thinks his health is being affected, he can always demand to be seen by the Medical Officer. The only point in which Field Punishment can be criticised from a medical point of view is that some men find it difficult to sleep handcuffed, but this part of the punishment is not often carried out.

It is a regrettable fact that such a punishment has to be imposed on our soldiers, but discipline can only be maintained by means of strongly deterrent punishments. The ordinary methods of dealing with "crimes" committed by soldiers on home service, such as confinement to barracks or stoppage of pay are quite impossible in the expeditionary force, where for practical purposes everyone is confined to barracks or their equivalent, and where money is of little practical use. All officers are convinced of the value of Field Punishment No. 1, and it is to be hoped that the shrieks of journalistic demagogues will not be allowed to frighten the Government into curtailing its employment.

It is rumoured that in future no qualified man will be allowed by the War Office to spend more than three months doing hospital appointments, but will then have to join the R.A.M.C. If this is true, and is put strictly into operation, it will mean that the system of house-appointments at the hospital will have to be considerably modified, as the Out-Patient Officers will no longer be able to proceed to appointments as House-Physicians and House-Surgeons. Further, it is quite possible that in some periods there will not be enough recently qualified men to fill the absolutely indispensable appointments. It is to be hoped that in such an event the War Office authorities will see their way to granting an extension of exemption to men who have completed three months of appointments. Though we are not in favour of retaining an unnecessarily large number of qualified men as Residents, there is a certain minimum which must be kept up if the hospital is to do its duty towards the civilian and military patients.

We are glad to hear that meetings of the Physiological Society are again being held regularly. It is unfortunate that so old an institution as the Physical Society should have been allowed to lapse during the war. There are still a considerable number of students in the wards, and we venture to think that they are not less keen on their work than in former days, though, perhaps, they may be harder worked. Many of the more senior students and house-officers remember the successful clinical and pathological meetings of the Physical Society as pleasant and easy opportunities for acquiring knowledge which was not easily forgotten. We feel sure that if meetings of the Physical Society could be organised during the rest of the winter, they would be well attended.

The response to our appeal last week for copies of medical works for transmission to Englishmen interned or prisoners in enemy countries has, so far, not met with the response that might have been hoped for. If anyone can spare any of the books mentioned in the list published in our columns on November 4th we hope he will send them forthwith to the Librarian of the Wills Library.

It is with great pleasure that we have to congratulate several Guy's men on their being awarded the Military Cross in recent Honours Lists. Among these is Mr. T. A. Townsend who was a year or two ago extremely popular here as Ophthalmic House-Surgeon. We have also had the pleasure of seeing back here on leave several Guy's men who have been in the Somme battle during the last few months. It is only from them that one can realise what terrible conditions have to be faced by our soldiers out there owing to the winter. In previous winters there had been but little attempt at active operations by either side, and in consequence the comfort of the men could be catered for much more thoroughly than is now possible. Present conditions, we fear, will make a great deal of sickness among the troops inevitable, and it will be difficult to take the precautions which last year rendered trench foot a comparatively rare occurrence in well-disciplined battalions. However, if we must lose a number of effectives through illness we can at least comfort ourselves by the thought that a similar wastage must go on among our enemies.

Honours.

Military Cross.

Temp. Lieut. S. J. Darke, M.B., R.A.M.C., for conspicuous and gallant conduct in the Field. Although badly wounded he worked for five and a half hours under heavy shell fire, tending the wounded without letting anyone know he was wounded himself. His gallantry throughout the operation was very fine.

Temp. Lieut. J. B. Dunning, M.B., R.A.M.C., for conspicuous and gallant conduct in the Field. He went into the open under heavy shell fire and tended the wounded until he was severely wounded himself.

Distinguished Service Order.

Major (temp. Lieut.-Col.) L. L. C. Reynolds (Oxford and Bucks. Light Infantry) for conspicuous and gallant action. He handled his battalion with great skill and determination. On two separate occasions his good leading has achieved success.

Obituary.

Captain M. J. REES, R.A.M.C.

Captain Morgan James Rees, R.A.M.C., died on October 30th, aged 41, of wounds received on October 22nd while attending to the wounded under fire. He was the younger son of the late John Rees, of Stepney, and was educated at the City of London School, at the University College of Wales, Aberystwyth, and at Guy's Hospital. He took the diplomas of M.R.C.S. and L.R.C.P. Lond. in 1902, the D.P.H. of the London Colleges in 1904, the degrees of M.B. Lond. in 1902, and M.D. in State Medicine in 1906. After filling the posts of Assistant Medical Officer of the Brook Hospital of the Metropolitan Asylums Board, and Assistant Medical Officer of Health to the County Borough of Reading, he became Medical Officer of Health and Superintendent of the Isolation Hospital for Aberdare Urban District in 1906, and in 1911 was appointed one of the Medical Inspectors of the Local Government Board. He was a Fellow of the Society of Medical Officers of Health, and of the Royal Society of Medicine, and a Member of the Royal Sanitary Institute.

He took a temporary commission in the R.A.M.C. a little over a year ago.

J. W. BEACOCK, L.D.S. England.

We much regret to record the death of Mr. John Walter Beacock, of Station Approach, Swanage, which took place on October 26th at the age of 25 years. He qualified from Guy's Hospital in 1914 and worked for a time as dentist to the Deptford School Clinic. His skill and care in his work were soon appreciated, and everything seemed to promise for him a very successful professional career. After a hard struggle against ill-health he passed away, to the great regret of many friends.

Demonstration of Cases from the Children's Department.

By Dr. CAMERON.

1. *A case of Congenital Syphilis in an infant, showing bony lesions, without any other marked symptoms.*

I show you here an infant two months old who was sent to me with the diagnosis of infantile paralysis. You see that as he lies, the left arm and the right leg are kept motionless, while he moves the other limbs freely. In a sense he is paralysed, but there is no disease of the nervous system. The limbs are kept motionless because pain has inhibited the muscular contraction. You may compare this baby's condition to that of a dog, with a crushed paw, running on three legs. The mother tells us that this is the first baby, born a year after marriage, apparently healthy. Three weeks ago, when the baby was five weeks old, it was noticed that he cried a great deal when being handled, and a little later that he had lost power in the arm and leg. In this so-called "syphilitic pseudo-paralysis" you will always find that the mother lays emphasis upon the pain and crying which follow on movement. If you watch the baby closely you will perhaps be able to detect that the child is *apprehensive* of being moved and cries at the approach of anyone who makes signs of lifting him. In infantile scurvy in which the hæmorrhages under the periosteum give rise to a very similar pseudo-paralysis, this apprehension on the part of the child is much more obvious, because the child is older. Syphilitic pseudo-paralysis always occurs about the second or third month; scurvy not until after the sixth month. The age of this child alone tells us that the cause of the pain on movement and the reflex immobility in this case is due, in all probability, to syphilis. Note, too, that this baby is breast-fed, and not fed, as is usual in scurvy, upon a dried malted milk.

The special interest in this case is, perhaps, the almost complete absence of other signs of congenital syphilis. It is true that if you listen carefully as the child cries, you will hear now and then an unmistakable inspiratory "snuffle." But such a snuffling sound often enough means no more than a nasal catarrh. Only when accompanied by a purulent or, still more, a blood-stained nasal discharge can we lay much emphasis upon snuffles as evidence of congenital syphilis. Examine this child carefully and you will find no trace of rash, and, if there has been one, the mother has not noticed it. The soles of the feet and palms of the hand show no disquamation; there is no stiffness or induration of the lips; the glands of the neck and the epitrochlear glands are not palpable. I have seen several other cases such as this in which the bony changes were very marked, while all other signs were absent or so little marked as to leave one in doubt. In one case an X-ray examination proved that the persistent crying of an infant when handled was due to syphilitic periostitis, although there was not even pseudo-paralysis to guide one.

In bad cases the periosteal overgrowth may be sufficient to be palpable. That is not so here. You may palpate both the paralysed limbs and the limbs which are not paralysed and in neither can you make out any thickening, yet both the X-ray photographs which I show demonstrate very extensive changes. These changes are of two sorts. There is, first, a thickening of the periosteum at the end of the long bones, giving a double shadow. In this case the periosteal overgrowth is present, but is not very marked. I show you a photograph from another of my cases. In it you will see the new bone laid down around the old and gripping it much as a cigarette holder sur-

rounds the cigarette. In the second place, and this change is well shown in the present case, the zone of calcification at the distal end of the tibia is widened and jagged, and in the centre of this widened zone is a clear space filled only with granulation tissue without bone.

I have given this child 2 grains of grey powder three times a day, and have told the mother, after the baby's bath, to rub gently into the skin, choosing a different place each day, a little ung. hydrarg. oleatum. Already there is marked improvement. The mother is to have salvarsan.

2. *Three examples of the Catarrhal State.*

The first two cases are brothers, aged respectively 4 and 2. You see that they are very like each other. Both are plump and rounded, with red shiny faces, narrow contracted chests, very prominent abdomens, cold blue hands and feet. They do not show any marked ricketty changes in the bones. On closer examination you will see that both have considerable nasal obstruction. The nostrils are atrophied and small, while the mouth is large and baggy, with full red lips always slightly open. These changes are due to overgrowth of the adenoid vegetations. The tonsils are very large, especially in the younger child. In both the glands in the neck are enlarged. You would be right to consider that both of these children might well be sent off post-haste to the Throat Department to have tonsils and adenoids removed, and no doubt benefit would result from doing so. But I show them to you to demonstrate that the condition is not local to the nasopharynx, but a general condition marked by persistent if somewhat quiescent catarrhs of all the mucous membranes, as well as of the skin. Besides a purulent discharge from the nostrils, both of these children at the moment have some chronic conjunctivitis, and the eyelids are reddened and inflamed. The skin of the cheeks in both is glazed and reddened and shows numerous little red papules; the younger boy has a patch of dermatitis in the fold behind the left ear, which has been present for many weeks; the older boy has a reddened and painful infiltration of the skin of the prepuce. Both have all their life suffered from attacks of bronchitis. The elder boy came to me a week ago for bronchitis and feverishness; he is now better, but the younger brother to-day is feverish and dyspnœic with signs of bronchitis. Both suffer often from looseness of the bowels and mucus is sometimes seen in the stools. If you were to take these children's temperature and chart it, we should find it constantly irregular with, in addition, numerous short pyrexial periods. These children show what I spoke of in my last lecture as "the catarrhal state." If an autopsy were to be made I have little doubt we should find considerable enlargement of most of the lymphatic glands in consequence of the persistent irritation of the corresponding mucous membranes, the so-called status lymphaticus. Here not only the adenoid vegetations, but many other groups of lymphatic glands are probably involved.

The diet of these children has been much at fault, and may be chiefly to blame. The mother says that they have huge appetites, consuming very large amounts of bread. She cuts them a slice of bread whenever they cry for it. Biscuits, cakes, bread and potatoes make up their diet, and they are, perhaps, suffering directly from carbohydrate excess. In my last lecture I showed you charts of the improvement wrought on such children by a suitable diet of meat, fish, eggs, green vegetables, cereal foods, and fruit.

I show you this third child, a little girl of three, who also is a great bread eater and suffers from numerous catarrhal infections. This last week the mother has been told to weigh the amount of bread taken daily. She says the child has had 16 ounces each day, about 1,200

calories. The child weighs 28 pounds, and her total need for food may be estimated at about 1,000 calories, *i.e.*, 83 calories per kilo body weight. In bread alone she has taken more than that amount.

3. *A case of Spastic Paraplegia in a child of sixteen months.*

This little boy, 17 months old, is brought because he cannot walk. He is small for his age. He weighs only 18 lbs., but he is active and intelligent. When lying down or sitting there is nothing much to be seen amiss with the child. But now, ask the mother to hold him upright. Immediately the spasm of the legs becomes apparent; the feet become pointed and dropped, with the great toes hyperextended. The adductor spasm keeps the legs pressed tightly together throughout their length as though encircled by an invisible bandage. If the child is held so that he may "feel his legs" and try to walk, the adductor spasm prevents him from advancing either leg; each seems to be fixed to the other. In the end he will learn to walk, but only after a long delay. The gait will be stiff and awkward, the so-called "scissor-gait." Raised on his toes he will take a very short step forwards and inwards, with difficulty hitching the internal condyle of the femur round and past its fellow to which it is always closely pressed.

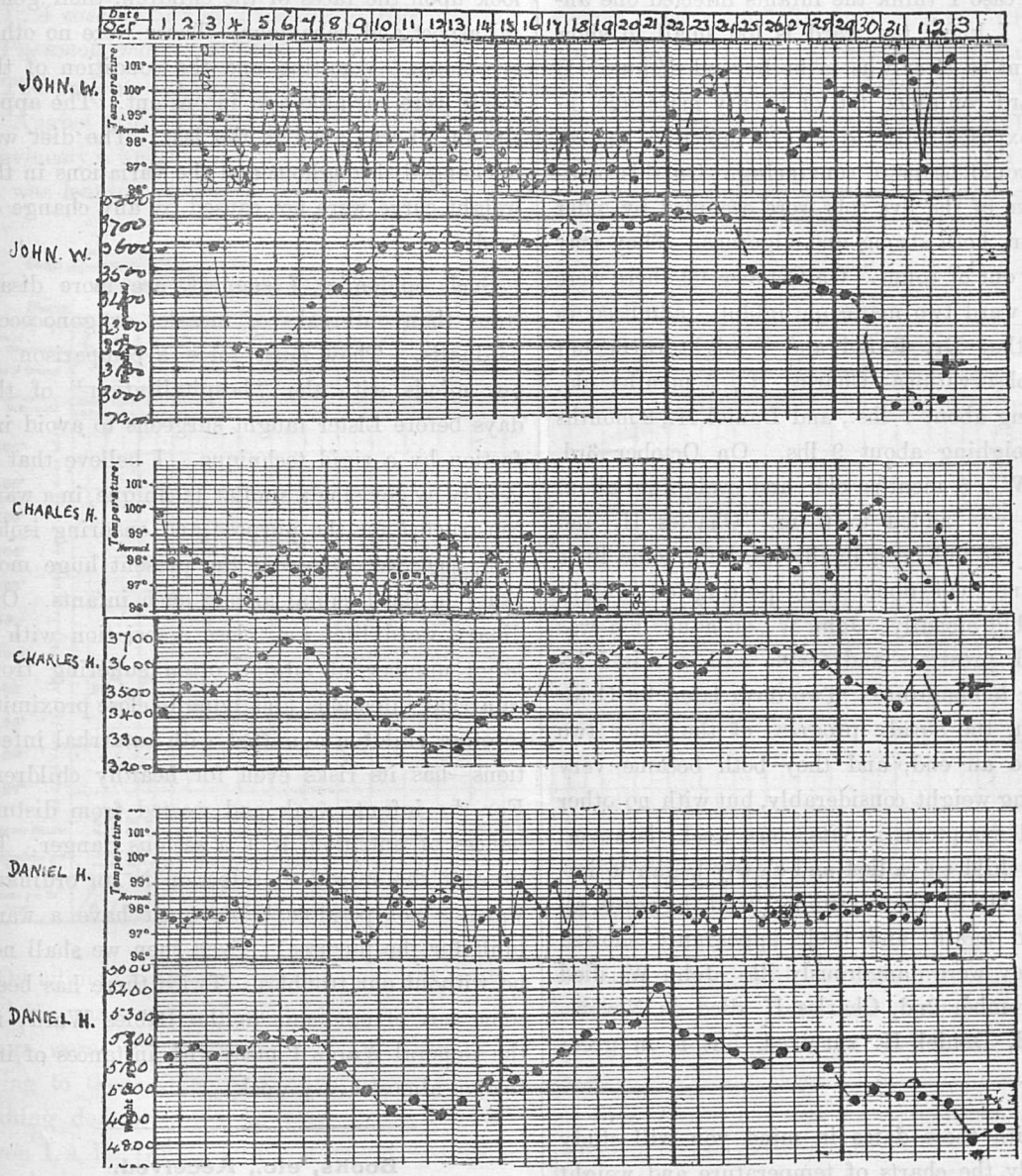
In some cases the upper limbs are also involved. Occasionally the muscles of the lips tongue and pharynx suffer as well, and speech is slowly acquired and faulty, and even swallowing may be difficult. Often there is some impairment of the mental power. On the other hand, in several cases I have found that the mental deficiency is less than has been thought. If speech is delayed and inarticulate sounds persist, and if the difficulty in swallowing leads to much dribbling of saliva from the mouth, the parents will almost certainly fear the worst and take too gloomy a view. In this boy the arms are little involved and the labio-glosso-pharyngeal muscles not at all. There is no history of trauma at birth or difficult labour or encephalitis. The defect is probably due, as in most cases, to a fault of development.

Warm baths, massage, passive movements to overcome spasm, and exercises to teach co-ordination will bring about great improvement. I have one case of great severity, in which a child three years old, who had been regarded as a hopeless idiot, has been taught both to walk and to speak a little within twelve months. His father, who is a schoolmaster, has made a careful and intelligent study of the necessary exercises and has produced such rapid improvement in his only son, that the local tribunal has granted him temporary exemption from military service to continue the good work, and I am not sure that he does not deserve it.

4. *The Hospitalisation of Infants. Marasmus.*

I now come to something more indefinite about which I speak with some diffidence. I have felt for a long time that the chief risk run by the most feeble and wasted infants which are admitted to the wards is the liability to infection. They are admitted with one complaint from which, perhaps, they recover; they are apt to contract another of which, perhaps, they die. Infection is, of course, the bane of all children's hospitals. In older children these infections are, as a rule, specific, measles, for example, or whooping cough, or gonococcal vaginitis. The symptoms are then clear and unmistakable. But the epidemics of catarrhal infections from which the marasmic infants are apt to suffer are remarkable because of their almost symptomless character. They are to be appreciated only by those who have considerable experience of infant disorders, and their presence is often unsuspected even though the mortality is very high. The feeble, flagging organ-

ism does not respond to infection by marked symptoms. Terminal infections, as we call them, are apt to be comparatively symptomless at all ages. Even in the specific infectious disorders whooping cough is only well heard when the child is strong and vigorous. Above all, these tiny and wasted creatures, the so-called marasmic infants, suffer severe and even fatal dis-



of childhood the characteristic symptoms may be slight and fugitive if the child is feeble and exhausted. Erysipelas in a wasted infant may be almost without redness, and the whoop of orders with a terrible paucity of symptoms. I have elsewhere published an account of an epidemic in the Babies Ward in which all five inmates went in some danger of their lives because

they were infected by contact with a nurse suffering from a pyrexial catarrh of nose and throat. We have just experienced another such epidemic which I shall describe to you, although in this case I think the infants infected one another. I know the ward is too small to show my point so clearly as to be beyond dispute. If the ward contained ten or twenty marasmic infants exposed to the spread of infection, the results would be more convincing. On this occasion two of the five cots were occupied by older children, both strong and vigorous. They may be left out of count. On October 1st there were in the ward two marasmic infants—admitted in order that Dr. Ryffel and I might carry out some observations—Charles H., 5 months old, weighing about 7 lbs., and Daniel H., 8 months old, weighing about 9 lbs. On October 3rd, John W., 5 months old, and weighing about 7 lbs., was added to them. Charles H. and Daniel H. had been in the ward for some little time and had done well, putting on weight slowly but steadily. John W., on admission was very ill, prostrate and feeble with a raised irregular temperature. Two days later, on October 5th, the steady progress of the other two came to an end, and they both became very ill, losing weight considerably, but with no other marked symptoms. After one week, however, all the children rallied and slowly began to improve. On or about October 22nd, however, all relapsed again, and their appearance showed that they were dangerously ill. John W. died on November 2nd, Charles H. died on November 3rd, Daniel H. survived, but is in great danger.

If with these dates in mind you will study carefully the charts of temperature and weight as here set out, you will see that the curves correspond fairly closely, but you must take it from me that the best evidence of the relationship between the three illnesses was afforded by the children themselves. Neither the weight curve nor the temperature curve show the course of the illness, with the initial attack and the subsequent fatal relapse, so clearly as did the look upon the faces of the children, their general aspect and behaviour. There were no other symptoms. Vomiting and the condition of the stools were variable and inconstant. The appetite in all was good to the last. The diet was unchanged throughout and the variations in the weight curve were not caused by any change of food.

Such epidemics, I suggest, are more disastrous than outbreaks of measles or gonococcal vaginatis. They must force a comparison in our minds with the "hospitalisation" of the days before Lister taught surgeons to avoid infection by a rigid technique. I believe that it is only by devising a similar technique, in a ward constructed for the purpose and ensuring isolation, that we can avoid the present huge mortality in the hospital among such infants. Ordinary ward life, *i.e.*, close association with a large number of adults, often suffering from catarrhal infections, and lying in close proximity to other children admitted with catarrhal infections—has its risks even for healthy children. For the infant, weak and wasted from disturbances of nutrition, it is a serious danger. To prevent the spread of infection in an ordinary ward is not possible. We must have a ward built for the purpose! Even then we shall not be without our troubles. Twice there has been some sort of epidemic in the Babies Ward; in the General Wards I meet with instances of infection almost every week.

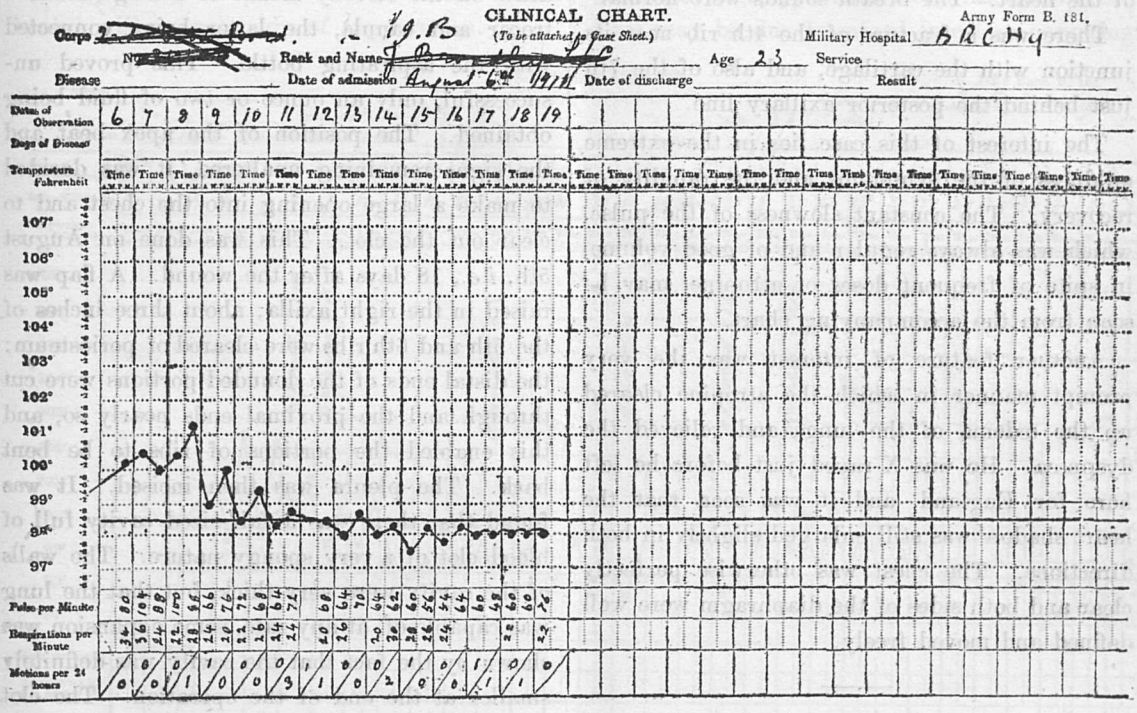
Books, etc., Received.

St. Mary's Hospital Gazette, The Hospital, The Nursing Times, The Hospital Gazette, Transactions and the Annual Report of the London Dermatological Society, Cardiac Curves and Sounds, by G. Arbour Stephens, M.D., B.S., B.Sc.

Notes on Two Cases of Injury to the Chest.

1. *A case of Simple Fracture of Ribs causing a Pneumohæmopericardium.*

The patient, L/Cpl. B., æt. 23, was admitted on August 6th. The history was that two days previously a weight had fallen on his back while he was leaning forwards.



On admission the temperature was 100°, pulse 80. He was very dyspnœic and cyanosed. Both lungs were very œdematous at the time, and owing to these pulmonary adventitious sounds, nothing definite could be made out. He was given I.A.H. 1/50. An examination was made about an hour afterwards and it was found that the lung œdema had completely cleared up. There did not seem to be any signs of a pneumothorax, but there was a loud splashing heard all over the cardiac area. This sound synchronised with the heart beat and was clearly heard by the patient.

By this time the patient felt perfectly comfortable. He was given I.M.H. $\frac{1}{4}$. He passed a very good night till about 4 a.m., when he again became dyspnœic and very "bubbly." He was relieved almost instantaneously by another injection of atropine (1/100). He was again dyspnœic at about 10 a.m. An X-ray examination showed that the cardiac opacity was enlarged to right and left, but there was a definite clear area above and to the left of the main opacity. The chest above the cardiac opacity was quite clear. The diaphragm was not seen on the left side as the cardiac opacity extended to the extreme left.

The chest was needled from behind, but was apparently empty. A needle was put into the left axilla into the the pericardium, and ten ounces of blood and a considerable quantity of air were drawn off. This gave great relief.

and except that for a few days the patient became "bubbly" at times, and was immediately relieved by I.A.H. 1/100, p.r.n., he remained perfectly comfortable. After the fluid had been drawn off, the splashings became much louder, but gradually went away, and were by August 9th replaced by a rub. This was at first heard over the whole of the cardiac area, but at the time of his transfer on August 19th was limited to the apex and was not heard with every beat of the heart. The breath sounds were normal.

There was a fracture of the 4th rib near its junction with the cartilage, and also of the 7th just behind the posterior axillary line.

The interest of this case lies in the extreme mildness of the symptoms and the rapidity of recovery. The constant slowness of the pulse, which was always regular and of good volume, in spite of frequent doses of atropine, may be seen from the accompanying chart.

Another feature of interest was the very prompt manner in which the atropine cleared up the œdema of the lungs and relieved the dyspnœa. He was X-rayed just before he left here for England, and it was seen that the heart shadow was still enlarged slightly in both directions. The chest was otherwise perfectly clear and both sides of the diaphragm were well defined and moved freely.

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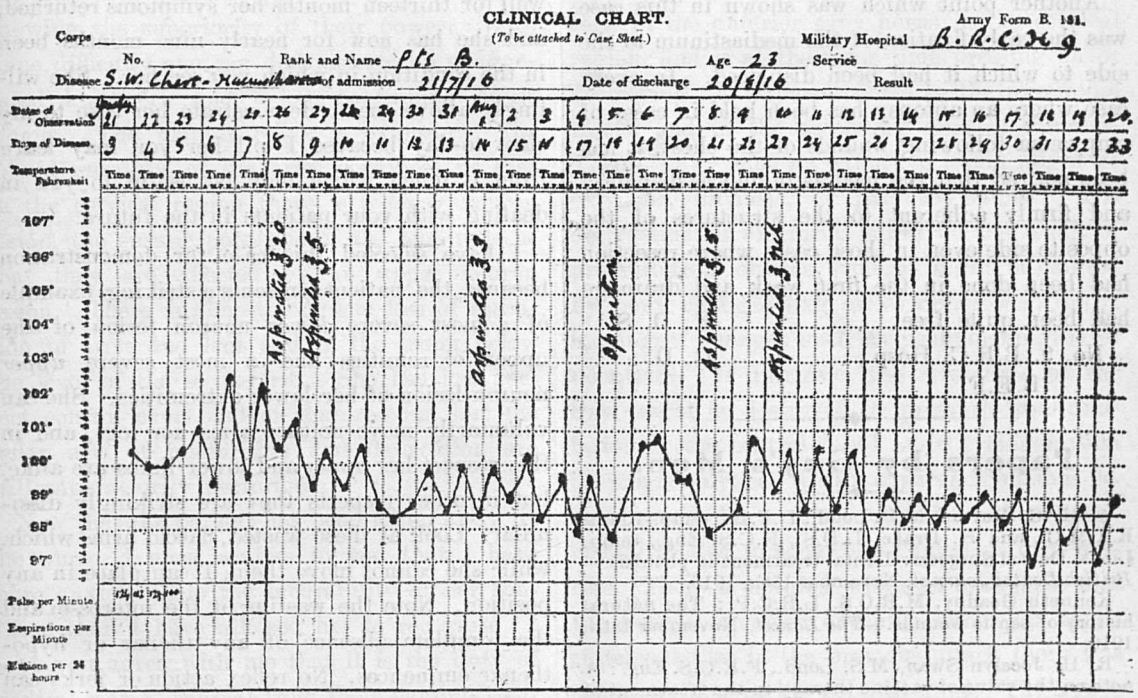
2. *A Case of Hæmothorax, in which Clotting interfered with efficient Aspiration.*

Private B., æt. 23, was admitted on July 21st. He had been wounded in the chest two days previously. On admission there were entry and exit wounds caused by a piece of shrapnel which had penetrated the right chest from before backwards. There were signs of a large right-sided hæmothorax, which had displaced the apex beat to the left mid-axillary line. He was moderately distressed; temperature 100·4°; pulse 124. He was aspirated on July 26th, till which time I.M.H., ¼ gr., was given p.r.n. By aspiration only 20 ounces could be drawn off, although the canula could be moved about freely and it was obvious that it was in a fair-sized cavity. The fluid was reported sterile. The aspiration did not relieve his symptoms and the position of the apex beat remained unaltered. A second attempt was made the next day, but this time only about 5 ounces could be drawn off. On August 1st an attempt was made to draw off the clot by means of a large bladder trocar and canula, the latter being connected with the aspirating bottle. This proved unsuccessful, only an ounce or two of fluid being obtained. The position of the apex beat and the signs remaining unaltered, it was decided to make a large opening into the chest and to clear out the clot. This was done on August 5th, *i.e.*, 18 days after the wound. A flap was raised in the right axilla; about three inches of the 5th and 6th ribs were cleared of periosteum; the distal ends of the denuded portions were cut through and the proximal ends nearly so, and this enabled the portions of ribs to be bent back. The pleura was then incised. It was found that there was a fair-sized cavity full of blood clot of a very spongy nature. The walls of the cavity were very thick, but that the lung was capable of, at any rate, some expansion was shown by the fact that the cavity was definitely smaller at the end of the operation. The clot was removed (digitally and with a blunt curette) as far as possible, and then was washed out with the irrigator. The pleura was sutured, the ribs bent back into position, and the periosteum, muscles and skin were then sutured separately. At the end of the operation the apex beat had come in slightly, but was as far out as the anterior axillary line.

On August 8th (three days later) the apex beat was slightly further out. Fifteen ounces of clear, blood-stained fluid, and a good deal of air, were aspirated. The apex beat was then

just outside the nipple. The next day it was in the anterior axillary line. From that time it gradually and persistently came in, and by the time of the transfer of the patient to England, was less than half an inch outside the nipple. The signs suggesting fluid persisted on the right side of the chest, but a further needling was negative, showing that the signs were due merely to thickening of the pleura. The patient was allowed up on August 11th and was walking about in a day or so. The wound healed without any sign of suppuration.



The interest of this case lies in the fact that, contrary to expectation, it is comparatively rare for clotting to take place in a hæmothorax, so that in most cases aspiration is effective. There have been over 80 cases of chest injuries here since the beginning of this year, but in only two cases has aspiration failed to draw off the fluid completely. In the other case, a rib resection was done, and the pleural cavity was drained. In that case, though the patient at first was greatly relieved, he became very ill after a few days when the contents of the cavity became septic, and convalescence was very slow and protracted. In all the cases where resection has had to be done on account of sepsis, it has always been found that though the immediate relief is often great, the patients tend to relapse after a few days and that the temperature does not settle for some weeks in spite of free drainage. In this way their course is very different from that of empyæmata met with in civil life. This may be due to mixed infection occurring, but also to the fact that there is damage to and infection in the lung. Possibly the infection in the lung is intensified after drainage by the increased movement of the latter. This makes one reluctant to resect at once even in cases where bacteriologically the fluid is found to be mildly septic, and it has been found that many such cases do very well with repeated aspirations. We have had three cases in which the fluid was infected by streptococci and in which

a satisfactory result was obtained without resection. One was aspirated many times, another once, and the third, in which the hæmothorax was quite small, was not aspirated at all. If, however, there is a large collection and it cannot be dealt with by aspiration, the ultimate result must be so bad that it seems rational to clear out the clot, even though one must run some risk of setting up infection. The hope that a sterile clot will soften and become a fluid which can be dealt with by aspiration would seem to be ill founded.

Another point which was shown in this case was the early fixation of the mediastinum to the side to which it had been displaced. In every case where an autopsy has been held in cases of empyæma following wounds of the chest, it has been noticed that the mediastinum was displaced and firmly adherent to the structures of the opposite side even in those cases where resection had been done in the first week and drainage had been quite free.

F. D. S.
C. D.

No. 9, B.R.C. Hosp.,
B.E.F.

Papers by Guy's Men.

A. H. G. Burton, M.D. Lond.. D.P.H., temp. Lieut. R.A.M.C., and H. Drake, L.D.S., R.C.S. Eng., temp. Lieut. Dental Surgeon: Dental treatment in phthisis.—*British Dental Journal*, November 15th, 1916.

Kenneth Goadby, M.R.C.S., L.R.C.P.: The natural history of septic wounds.—*The Lancet*, November 18th, 1916.

R. H. Jocelyn Swan, M.S, Lond., F.R.C.S. Eng.: A note on the value of vaccine therapy in the treatment of septic gunshot wounds.—*Ibid.*

Capt. E. W. Ainley Walker, M.A., D.M. Oxon., O.T.C.: Illustrations of the diagnostic value of agglutinin determinations in inoculated individuals.—*The Lancet*, November 25th, 1916.

Change of Address.

Capt. R. C. Matson, R.A.M.C., Vale Lodge, Epsom Road, Guildford, Surrey.

Capt. E. C. W, Starling, R.A.M.C., S./R., from No. 1 M.A.C. to 63rd Field Ambulance, B.E.F., France.

Lieut. H. Mather, R.A.M.C., Officers' Mess, R.A.M.C., Delhi Barracks, Tidworth.

I, Tewfik, M.R.C.S., L.R.C.P., Royal Infirmary, Chester,

Demonstrations in Clinical Medicine.

By Dr. LAURISTON SHAW.

1. *Cervical Paraplegia.*

Charlotte H., æt. 53, sets us all an example of fortitude in suffering and hopefulness in adversity. We encourage her optimism by reminding her that she was in almost as bad a plight in 1914, and that after nine months' illness she entirely recovered. Unfortunately, after being well for thirteen months her symptoms returned, and she has now for nearly nine months been in the condition in which you see her. She willingly allows me to demonstrate her case to my class to-day because I tell her you may learn from it much which may be useful to you in dealing with your patients in the future.

I have selected this case for demonstration because the patient presents a striking example of a most severe *lower* neuron lesion of the upper extremities and a most severe *upper* neuron lesion of her lower extremities. She can voluntarily move neither arms nor legs, and in this respect her upper and lower limbs are alike, but in other respects they are strikingly dissimilar. Look at these wasted, flaccid arms which, while she cannot move them, I can place in any position. Note the wasting of the interossei and the complete absence of any thenar or hypothenar eminences. No reflex action or jerks can be elicited. I am not sure if the response of these muscles to electrical currents has been tested, but if it were we should find that there was what is called the electrical reaction of degeneration of the nerve.

Now note the different condition of the legs, which she cannot herself move, but which occasionally present spontaneous contractions. The thighs are firmly flexed on the abdomen and the legs on the thighs, whilst the two thighs are so strongly adducted that, as you see, the nurse

has to use considerable force to remove the pillow which has been placed between her knees to prevent the evil effects of pressure. The heels are not in contact with the buttocks, but they approach them so closely that one is reminded that in such a condition, if care is not exercised in nursing, a bed sore may be caused on the buttock by the pressure of the heel. I cannot straighten these limbs without using great force and causing the patient pain. Her muscles, though making no response to messages she may send from the cortex of her brain, are constantly exercising much force, the flexors showing the superiority of their power. With some difficulty one can demonstrate an exaggerated knee-jerk and a long-continuing ankle clonus. The plantar reflex is extensor. The flaccid paralysis of the arms convinces us that in the cervical region there is a *lower* neuron lesion, the spastic paralysis of the legs tells us that they are affected by an *upper* neuron lesion. There is almost complete loss of sensation in arms and legs and in the trunk below the level of the second rib. She has lost perfect control over bladder and rectum, but the reflex acts of micturition and defæcation are still satisfactorily performed.

Now that the patient has been taken away by the nurse, I must confess to you that I have more anxiety as to the incurability of her condition than I have allowed her to recognise. I hope you agree with me that it is the duty of medical men to conceal from their patients their learned doubts, especially when they are of a gloomy character. I had not the advantage of seeing this patient in her previous attack, and I have not at present formed any certain opinion as to the exact pathological nature of her lesion. It seems, however, unlikely that such extensive destruction of nerve tissue, whatever may be its cause, can be recovered from.

I will now endeavour to answer the three questions I always encourage you to ask and try to reply to in all cases of suspected disease of the central nervous system. 1. Is there a lesion? Undoubtedly yes. You are all familiar with the condition of functional or hysterical paraplegia. It is entirely different from this. 2. Where is the lesion? Clearly we have here two lesions, primary and secondary. The primary lesion is situated in the cervical enlargement of the cord, and there is a secondary descending lateral sclerosis extending down to and through the lumbar enlargement. 3. What is the lesion? We are sure it is a lesion which is causing wide-spread destruction of the grey cells in the anterior grey horns in the cervical region, and is at the same time pressing on or destroying the adjacent fibres in the pyramidal tracts, and in the ascending sensory columns. Theoretically such an extensive lesion might be extrinsic, intrinsic, or parenchymatous. The destruction, if extrinsic, might be the result of pressure from outside, such as might be exerted by bony changes like caries or growth, or by meningeal changes such as pachymeningitis or neoplasm. If intrinsic, the structures of the cord might be destroyed by pressure from dilatation of the central canal as in syringomyelia or hæmatomyelia, whilst a parenchymatous lesion would be a focal myelitis, either spirochætal or due to some other inflammatory process. There is nothing whatever to suggest that the bone is involved except a somewhat vague statement that in the previous attack there was some swelling in the cervical spine. The X-rays show no bony changes. Neoplasm seems very unlikely in view of the complete temporary recovery. There is no history of injury such as might cause a hæmatomyelia.

The diagnosis, therefore, seems to rest between syringomyelia, myelitis, or pachymeningitis. There are none of the special sensory signs or joint changes of syringomyelia. As opposed to pachymeningitis, there are now no signs of pressure on the sensory roots, though in

the former attack radiating pains down the arms were prominent. On the whole, I am, however, inclined to a diagnosis of hypertrophic cervical pachymeningitis. There are no features in the history suggesting syphilis, but in view of her former recovery and of the fact that during her previous illness she was treated with iodide of potassium, we are pursuing antisyphilitic treatment. No Wassermann test has been applied, since whatever the result we should not abandon this treatment. I am bound to say, however, that there is as yet no material improvement in her condition as the result of our remedies.

2. *Intrathoracic Aneurysm.*

At my last demonstration I showed you a case of intrathoracic tumour obviously due to growth. I am glad to have an opportunity to-day of showing a parallel case in which the tumour is quite obviously an aneurysm.

Richard W., æt. 48, had syphilis whilst serving in the army in India at the age of 20. He was well till 12 months ago. During the past year he has suffered from thoracic pain, cough, aphonia, and dyspnœa. As you see him to-day you notice that he is slightly cyanosed. The area of abnormal dulness has been marked by my ward clerk on the chest, and you see it extends upwards from the cardiac dulness to the supra-sternal notch and under the clavicle on the right side. There are numerous distended venules over the chest, and some of these are connected with large veins coursing over the abdomen. By emptying these veins by stroking them alternately upwards and downwards it is clear that the blood stream in them is directed towards the groins. When I place my finger in the supra-sternal notch, I think you can all see that it is distinctly raised at each heart beat. Those who are close can see that the left pupil is larger than the right. You must take my word for it that the left pulse is felt with difficulty, whilst the right is large and distinct. My ward clerk tells me that the smaller pulse is also a little delayed. He also tells me that the blood pressure in each radial is below 100 and the smaller pulse shows less pressure than the larger. When the patient takes a breath you can hear a harsh stridor, and when he tells us his name you notice his voice is distinctly aphonic. Mr. Mollison tells us that his larynx presents the appearances of paralysis of the right recurrent laryngeal nerve.

From all these signs it is quite clear that this patient is suffering from an aneurysm of his thoracic aorta. It is obviously pressing on his trachea (stridor), his sympathetic nerve (unequal pupils), his recurrent laryngeal nerve (aphonia), his superior vena cava (reversed venous blood stream), and interfering with the origin of the vessels to his upper extremities (unequal pulses).

There are, roughly, three chief situations which may be recognised as the site of origin of a thoracic aneurysm: the ascending, the transverse, and descending aorta. The perfect closure of the aortic valves, as shown by the absence of any change in the second cardiac sound, and the normal entry of air into the left lung, as shown by the equality of signs at the two bases, would naturally make us disinclined to locate the aneurysm either in the first or in the descending part of the aorta. At the same time the structures which are actually showing evidence of being pressed on, make it clear that the aneurysm is involving the transverse arch.

I want to warn you of the great necessity of determining whether a combination of aphonia and stridor is due to a single laryngeal lesion or to a mixed laryngeal and tracheal condition. If the larynx alone is involved, any urgency of dyspnœa can at once be relieved by tracheotomy, but when, as in this case, the aphonia is due to paralysis of one cord and the dyspnœa to tracheal obstruction, the introduction of a tracheotomy tube will be of no avail. I have

seen a patient deeply cyanosed from tracheal obstruction die of hæmorrhage on the operating table without any relief to his dyspnœa from opening the trachea undertaken under the belief that the obstruction was in the larynx.

As to the cause of the aneurysm, there can be no doubt that it is due to syphilis contracted while serving as a young soldier. One hears with great anxiety of the temptations and risks to which our huge armies of young men are now being subjected. There is a great opportunity for you senior students and recently qualified practitioners to take part in the campaign for spreading amongst our soldiers a knowledge of the serious dangers of venereal diseases. I think they are more likely to pay attention to you than to us of an earlier generation.

3. *Splenomegalic Hypertrophic Biliary Cirrhosis.*

John D., æt. 25, now a worker in leather not involving the use of any chemicals, was, until a few months ago, a barman. For two and a half years he has been affected by a gradually deepening jaundice accompanied by an increase in the size of his waist. The jaundice, as you see it, is distinct, but not extremely deep; his urine is bile stained; his motions are not free from bile. The lower margins of liver and spleen are easily felt and the outlines are marked in ink upon the abdomen. The liver is probably twice as large, and the spleen, perhaps, four or five times as large as normal. Both organs are smooth and slightly hardened. There is no free fluid in the abdomen. The patient is by no means seriously ill. He was led to seek admission by reason of an acute attack of diarrhœa, but this being recovered from, he feels fit to return to his work. He was sent to me with a provisional diagnosis of Banti's disease. You may remember I showed you last time a boy with primary splenomegaly whose spleen was removed partly because we feared it might convey poisons by the portal vein to his liver and produce the condition originally described by Banti. In such a condition, however, the cirrhotic tissues of the liver surrounds and compresses the portal vein and much ascites and little jaundice is produced. The marked jaundice in this case and absence of ascites makes one think the change in his liver is surrounding and obstructing the bile ducts. The splenic enlargement is probably secondary to the hepatic condition. Despite the fact that this patient has been a barman, I do not regard this as a case of alcoholic cirrhosis. These cases are rare and their cause quite obscure. In the absence of any knowledge of their exact pathology it is impossible to suggest any more suitable name than *splenomegalic hypertrophic biliary cirrhosis* which, lengthy and clumsy though it is, has the advantage of indicating the main clinical features and gross post-mortem changes.

Appointments.

Royal Navy Medical Service.

Surgeon F. C. Hunôt to Royal Naval Hospital, Cape.

Temporary Surgeon R. Creasy to the *Crescent*, additional for Royal Naval Sick Quarters, Queensferry.

Royal Naval Volunteer Reserve.

To be Surgeon Probationer—J. Black.

Royal Army Medical Corps.

E. H. Durham, F.R.C.S., to be temporary Hon. Lieutenant whilst employed with the Welsh Hospital, Netley.

Temporary Lieutenants to be temporary Captains:—F. Morres, R. D. Attwood, A. H. Spicer, C. A. R. Gatley.

Temporary Capt. J. H. Jones to be temporary Major whilst commanding troops in a Hospital Ship.

To be temporary Hon. Lieutenant:—D. O. Richards.

To be temporary Lieutenant:—T. S. Robson.

Temporary Captain relinquishing his Commission:—J. A. Glover.

Temporary Lieutenants relinquishing their Commissions:—H. M. Hardy, H. D. Wyatt.

H. E. Marsh, L.D.S., has been appointed 2nd Lieut., R.F.A. (T.).

H. S. Crapper and C. L. D. Taylor have been appointed Army Dental Surgeons with the rank of temporary Lieutenant.

Civil.

I. Tewfik, M.R.C.S., L.R.C.P., has been appointed Senior House Officer to Royal Infirmary, Chester.

Guy's Hospital War Savings Association.

The Guy's Hospital War Savings Association was audited on Monday, October 16th. Up to Quarter Day, September 29th, the members numbered 242, and the contributions amounted to £167 0s. 6d., with which 215 certificates had been purchased. Since that time the Association has grown week by week, though not so quickly as might have been hoped, and at the present date (November 14th) the number on the books is 265; £282 7s. 3d. has been paid in, and 362 certificates purchased.

It is stated that Guy's is the only hospital in London which has started a War Savings Association, and it is greatly to be desired that this should be as largely representative as possible. The Association includes members of the Staff, or their children, Sisters, Nurses, Administrative Officers and Staff, Workmen, Porters, and Wardmaids, but as yet none of the House Officers or Students have given their support, which would be very welcome.

The "unit" of contribution is sixpence, and the "unit," or any multiple of it, will be gladly received, week by week or at longer intervals, in the Counting House or in the Superintendent's Office. By the rules of the G.H.W.S.A. all money received in any week is at once invested to its full extent in War Savings Certificates, which are allotted to the members on completion of each payment of 15s. 6d. The advantage of belonging to an Association is that, as more Certificates are usually purchased each week than are allotted, the surplus forms a "stock" of Certificates of various dates. It, therefore, usually happens that a Certificate, when gained, bears a much earlier date than that of the completed payment, and consequently "matures" earlier, thus increasing the rate of interest.

With regard to War Savings Certificates as an investment, it may be interesting to quote from "War Savings," the Journal of the National War Savings Committee :—

"Those who wish to compare the advantages of investing their money with their country in Six per Cent. Bonds and in War Savings Certificates may note the following points."

"The Six per Cent. Exchequer Bond is repayable at the end of three years and is subject to Income Tax, which, even at the present minimum of 3s. in the £ on unearned income, reduces the return to £5 2s. per cent., whilst the War Savings Certificate is entirely exempt from such tax and gives a return of £5 4s. 7d. per cent. per annum for five years."

"If it is desired to realise the capital value of an Exchequer Bond before maturity, the Bond must be sold at market price, which is bound to vary from time to time. The War Savings Certificate is, however, repayable at a few days' notice for a definite sum known beforehand, and this is never less than the amount paid. On the other hand, Exchequer Bonds are more readily available for loans from Bankers than is the case with War Savings Certificates."

"The smallest denomination of Exchequer Bonds is £5, and a small investor has to go without interest until he has saved this amount; whereas if he invests in War Savings Certificates he begins to receive interest directly he has saved 15s. 6d., or earlier if he belongs to a War Savings Association."

"The interest on the 15s. 6d. accumulates, whereas the interest on Exchequer Bonds is paid to the owner, who probably spends it."

"Our advice would usually be to buy 500 Certificates first and then to purchase Exchequer Bonds."

Thus, in the purchase of War Savings Certificates through the Guy's Hospital War Savings Association the members may feel that they are doing a patriotic action by helping to

minister to the Country's needs, and that they are contributing to the success of the Guy's effort. It is also true that the War Savings Certificates are a thoroughly good investment, and that money could not be more advantageously placed, especially when it is paid through an Association.

It is hoped that many more may see their way to contribute before the next audit takes place.

Guy's Hospital Physiological Society.

The First Ordinary Meeting of the Seventeenth Annual Session was held on Monday, November 13th, at 4 p.m. Dr. Pembrey was in the chair, and Mr. W. W. Payne read a very entertaining paper entitled "Abnormal Psychology."

There was a good attendance of members, and the considerable number of them who took an active part in the discussion which followed testified to the interest Mr. Payne's remarks had aroused. He began by giving a short historical resumé of man's belief in the supernatural, and went on to mention instances which give colour to that belief at the present day, when the causes of most natural phenomena have been accounted for scientifically. He related many examples of curious things that have happened and which cannot be easily explained on materialistic grounds, such as the apparent manifestation of the "subliminal self." Moreover, Mr. Payne produced statistics to show that a large number of experiments, conducted apparently by supernatural agency were "positive" in far more instances than were required by the law of chance alone.

Whether a materialistic explanation will be found for many things now regarded by some as evidences of the supernatural, or whether the development of an extra sense will account for them, time alone will show.

Two Unusual Cases of Intussusception.

Case 1.

J. M., m., æt. 6 months, an only child, was suddenly seized with abdominal pain and vomiting, the attacks of pain coming on at regular intervals with painless periods between. I saw him five hours after the onset of pain. He was a fine, fat, healthy-looking child and had been breast fed.

On examination the abdomen was flaccid, and the usual tumour was detected in the right iliac fossa. This became hard during the examination and the child screamed. He had had his bowels opened twice previous to my visit, and while I was present passed some pure blood and mucus. Intussusception was diagnosed.

At the operation, six hours after the onset, I reduced the intussusception easily by pushing and squeezing the mass. After reduction, the apex, which was about six inches above the ileo-cæcal valve, was felt to contain a hard, rounded substance about the size of a marble. The gut was incised, and a small sessile polypus was cut out of the bowel, an oval-shaped piece of gut being removed with the growth. The intestine was then closed with a double row of Lembert sutures, and the abdominal wound stitched together *en masse* with silkworm-gut. The child made an uninterrupted recovery and was reported one year later to be in perfect health.

Case 2.

E. C., blacksmith, æt. 55, was seized with severe abdominal pain after breakfast at 9 a.m. His bowels were opened, but with no relief from the pain, which was intermittent and became worse; there was no vomiting. I saw him at 4 p.m. when he was a little easier. Pulse 76; temperature 98·4°; no rigidity, tenderness, nor

vomiting, and as he had had his bowels opened at 9.30 a.m., a carminative mixture was given.

He was again seen at 11 a.m. on the following day. He had vomited once during the night, and he had had very severe pains. His bowels had not been opened again nor had flatus been passed.

On examination the abdomen was not very distended. A rounded, slightly moveable, sausage-shaped tumour could be felt in the right iliac fossa. Acute intestinal obstruction was diagnosed due to carcinoma of cæcum, a hard lump of fæces possibly causing the acute obstruction as he had had no abdominal symptoms before.

He was advised to go to the Cottage Hospital at once for operation, and morphia given. Unfortunately the morphia eased his symptoms; he would not come in for another 24 hours, and then would not be operated upon until the vomiting had become fæculent and the pain intolerable 62 hours after the onset of the stranlation.

I opened the distended abdomen to the right of the middle line and immediately recognised the mass as an intussusception. This was reduced with difficulty by squeezing and pushing, it being thought unsafe to pull the gut out after being intussuscepted such a long time. At length the bowel was reduced and two doubtful patches about the size of a shilling were seen. These were greyish black in colour, but as the peritoneum was shiny, they were given the benefit of the doubt and returned to the abdomen. The apex of the intussusception was about 8 inches from the ileo-cæcal valve, and the whole intussusception measured 18 inches. No evidence of growth could be seen or felt, nor was there any sign of a polypus in the gut. Beyond some diarrhœa and stools which contained mucus, he had no bad symptoms, and is now, twelve months later, in perfect health.

The diagnosis should have been easy because the tumour had the smooth elastic feel of an infantile intussusception, but owing to the man's age, this was not thought of.

O. V. PAYNE, M.B., B.C.,
Surgeon, Alton Cottage Hospital.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR MR. EDITOR,—You have been good enough to include my name among the "Roll of War Service," but state that I am on the *Glengorm Castle*. I left that good ship a year ago, after ten months' useful service, but am now at this hospital as R.M.O. It is not exactly war service, but I have 200 wounded here besides civilians. You may be surprised that an unqualified man is holding such a position. It came about in this way. I came as H.P. with charge of about 50 beds, when, after about two months, the H.S. was called up. The Medical Board gave me a unanimous invitation to carry on alone and increased the salary. So here I am still, instead of finishing the last exam. of the Colleges. As you may imagine, it is very useful work—more useful than ornamental, or rather more practical that theoretical. So some day I must come back to dear old Guy's for a brush up before trying conclusions with the Examiners in London and Cambridge.

In closing may I say that I never enjoyed the GAZETTE more than lately, One needs to get away from Guy's to see it in its magnificent perspective.—Yours faithfully,

J. STANLEY ELLIS.

Essex County Hospital,
Colchester,
Nov. 17th, 1916.

"The Meaning of the National Mission."

SIR,—To question the fundamental truths of the Christian religion, or to seek for philosophical proof of an existent belief, appears to me a sorry method of promoting repentance and faith in Jesus Christ which must be the result of any revival that is worth anything, For consider where such philosophy can lead men—no further than the old heathen Socrates believed when in his defence he said, "I am more convinced of the existence of God than my accusers; and so convinced that I abandon myself to God and you that you may udge me as you shall deem best for yourselves." What the nature of his God might have been we may infer from the fact recorded that the night before his death he composed a hymn in honour of Apollo and Diana and turned one of Æsop's fables into verse! His knowledge was less than that of the Jews, who believed in

one Almighty God. Yet their belief was of no use to them, for they killed the Lord of Life and Glory. It was merely a knowledge, a belief in God's existence no greater nor any more vital than the belief of any of us that there were such people as Pilate or Judas Iscariot. Our Lord says as much in St. John xvi. 2 & 3, "The time cometh that whosoever killeth you will think that he doeth God service." This is mere belief in existence, for He continues, "And these things will they do unto you because they have not known the Father nor me."

The greatest evangelist the world has ever known or will know says in his first Epistle to the Corinthians 11 & 13, "The natural man receiveth not the things of the Spirit of God: they are foolishness to him, neither can he know them because they are spiritually discerned," and so he says his message is to preach Christ crucified, unto the Jews a stumbling block and unto the Greeks foolishness, but unto them which are called Christ the power of God and the wisdom of God. For not many wise men after the flesh, not many mighty, not many noble are called, but the weak and the foolish hath God chosen. The work of a mission is to find out these weak but chosen ones. This can only be done by those who know these things for themselves. Others are merely blind leaders of the blind. To attract a man into the Church is one thing: it may be done by anybody. This is as far as most people go—just to the point where the Jews, the pharisees and scribes were. To get to the bed-rock of Christianity—to Jesus Christ Himself—is only possible to him who has had the divine revelation such as St. Paul had. And this revelation is mostly made by the foolishness of preaching or reading the word of God, with prayer and faith; not by philosophical disputation.—Yours faithfully,

B. JONES, M.D.

Letters from Old Guy's Men on Active Service.

B.E.F.,
Nov. 5th, 1916.

Dear Sir,—The weather out here at the present moment is like the demons of hell let loose, as it is blowing a sixty-mile gale with bursts of driving rain. As a result of all this, I expect to part company with my tent any moment; in fact, my servant wanders round about every half-hour driving the guy rope pegs in. Still it is wonderful how used one gets to this life.

In the old days one groused if there was a half inch of mud on the streets; now you don't notice it if it is six inches deep, and as I am at the horse lines at present I find the whole place a veritable quagmire.

Am hoping for leave before long—had none for nine months. When it comes shall be round the Hospital.—Yours, etc., E. JACKSON BROWN.

Field Post Office,
Sheikh Saad,
Mesopotamia Exp. Force,
c/o India Office,
October 9th.

I will tell you how I am getting along in jolly Mesopotamia. I travelled out the whole to Basra with Campbell, and we enjoyed ourselves tremendously. We both applied for field ambulance and hoped to remain together, but this was not permitted by the Olympians.

I am now travelling up to Sheikh Saad as O.C. of troops on one of the river boats on the Tigris. The conditions of existence are very simple. There is no cabin, and I have to arrange my own feeding. There are no other officers except the ship's officers, and they are not wildly exciting. In fact the Captain's one subject of conversation seems to be, that all parsons ought to be hanged or, alternatively, burnt. Fortunately there are two very nice sergeants on board. The troops on board are nearly all Indians. Of course the boat is too small to allow of any exerise. However, this is the last day of it, unless we stick on a mud-bank, and then I shall join a field ambulance or a regiment.

Hirsch was at Bombay, but I did not see him, worse luck, I would have given anything to see him in shorts. Gaymer Jones was in Hospital at Basra, and was just discharged on the day I saw him. I was on the same ship as Eccles, from Malta to Bombay, and he was hoping to get a job as X-ray man in India. I also met his brother at Amara.

The climate out here now is very good, if you have enough warm clothes at night. Basra is a very interesting place. It is intersected by creeks from the river, and you go from one place to another by boat, like Venice. There are many Arab villages along the river bank. They are very primitive, and the houses are either mud huts or made of matting fixed over poles. The whole country reminds one of the Bible, not, however, of that chapter about the Garden of Eden.

I have just remembered that this letter may not get you at all, as I do not remember your address except at Guy's, and if you are not there they will probably not forward it. However, I don't care, I have not had a mail from England since I left, and it will be months, probably, before I do, so what does it matter.—Yours,

PERCIVAL D. H. CHAPMAN.

Pass List.

Royal College of Surgeons of England.

At the Primary Fellowship Examination in Anatomy and Physiology held on May 3rd and 4th, A. J. McNair, M.B., B.S., and J. Victory were successful. We regret, through an oversight, this announcement has not been published earlier.

At the Final Examination held recently for Licence in Dental Surgery, the following candidates were success-

ful;—*Part I.*—P. Green, C. C. Becker, K. C. Brough, F. G. P. Flanders, H. O. Irwin, F. R. Salsbury. *Part II.*—P. Green, F. R. Salsbury, A. H. Bowes, W. A. Cooper, R. L. Cowley, L. H. Dixon, C. F. Hawkins, P. H. Marsh, W. Mercer, S. Sanders, H. Wallis, G. W. Wheldon, W. R. Wotton, J. A. S. Wright.

Notices.

The National Mission.

An address on the National Mission will be given by the Rev. W. Temple in the College Smoking Room, at 8.0 p.m., on Wednesday, December 13th. The chair will be taken by Colonel Charters Symonds, C.B., Consulting Surgeon to the Hospital. All Students are invited.

Guy's Hospital.

Applications are invited for the following appointments—

(*a*) Assistant to the Physician for Diseases of the Skin.

(*b*) Assistant to the Genito-Urinary Surgeon,

in the Department for Venereal Diseases during the year 1917. The salary for each appointment is at the rate of £150 per annum. Further particulars may be obtained from the Superintendent.

If an Officer holding a commission in the R.A.M.C. is selected for either of these appointments, application will be made to the War Office to relieve him in whole or in part of his Military Duties.

Candidates should send their applications to the Treasurer, at the Superintendent's Office, Guy's Hospital, on or before Tuesday, the 12th proximo.

Royal College of Surgeons of England.

NOTICE CONCERNING THE CARTWRIGHT PRIZE.

1. The Cartwright Prize will be awarded quinquennially, and the next award will be for the five years ending 31st December, 1920.

2. The Prize consists of a Medal executed in bronze and an honorarium of £85.

3. The subject for the essays to be submitted in competition for the Prize is "The Treatment of Injuries of the Jaws, and the restoration by mechanical means of parts of the Jaws lost as the result of injury or removed on account of disease."

4. Candidates for the Prize must be persons engaged in the study or practice of Dental Surgery and possessing qualifications capable of registration under the Medical Acts of the United Kingdom. (A Diploma or Licence in Dental Surgery without a Medical or Surgical Diploma or Degree will not be a sufficient qualification.)

5. The Prize will be awarded to the author of the best essay written in English upon the proposed subject, if such essay is considered of sufficient merit.

6. Every essay must have a motto or device and must be accompanied by a sealed paper containing the name and address of the author, and having on the outside a motto or device corresponding with the motto or device on the essay.

7. Each essay must be addressed to the Secretary of the Royal College of Surgeons of England, and delivered at the College not later than 4 o'clock p.m. on the 31st December, 1920.

8. The manuscript Prize essay and every accompanying drawing and preparation will become the property of the Royal College of Surgeons of England.

9. Every unapproved essay, which is unclaimed at the expiration of twelve months from the date of its receipt, will be returned with any accompanying drawing and preparation to the author thereof at the address given in the sealed envelope.

S. FORREST COWELL,
Secretary.

Rugby Football.

GUY'S v. ST. BART.'S.

This match was played at Winchmore Hill on Saturday, 25th. Rain and snow prevailed during the whole of the game. Weather conditions made back play impossible. The forwards rose manfully to the occasion, but were not good enough for their opponents.

Guy's were a man short; nevertheless, the score at time stood at 3 tries (9 points), Guy's nil.

FIXTURES.

Sat., Dec. 2.	—Guy's v. New Zealand Convalescent Camp	Home.
„ „ 9.	—Guy's v. Royal Flying Corps, Oxford	Home.
„ „ 16.	—Guy's v. R.M.A., Woolwich ...	Away.
Wed., Jan. 10.	—Guy's v. "The Wanderers" ...	Home.
Sat., „ 20.	—United Hospitals v. Grove Park, A.S.C.	Away.
„ Feb. 3.	—Guy's v. Artists' Rifles, O.T.C...	Away.
„ „ 24.	—Guy's v. St. Bartholomew's ...	Home.
„ Mar. 3.	—Guy's v. Artists' Rifles, O.T.C...	Home.
„ „ 10.	—Guy's v. R.M.A., Woolwich ..	Away.
„ „ 17.	—United Hospitals v. Grove Park, A.S.C.	Home.
„ „ 24.	—Guy's v. H.A.C.	Home.

Birth.

POWELL.—On October 25th, at Lindum House, Hamilton Road, Lincoln, the wife of R. Wood Powell, L.D.S. Eng., of a son.

Marriages.

STALLMAN—GALAVAN.—On November 14th, at St. Anne's Church, Upper Kennington Lane, by the Very Rev. Monsignor Canon Howlett, D.D., uncle of the bride, J. F. H. Stallman, M.B., B.S., temp. Lieut. R.A.M.C., eldest son of Mr. and Mrs. J. H. Z. Stallman, of "Braemar," Thurlow Park Road, Dulwich, S.E., to Mary, second daughter of Mrs. M. H. Galavan, of Tramore, County Waterford, Ireland.

CHARLES—BAILEY,—On November 2nd, at Builth Wells Parish Church, by the Rev. G. B. Charles, Vicar of Paddock Wood, father of the bridegroom, and the Rev. S. H. Wenham, Vicar, step-father of the bride, George Frederick Charles, Capt., attached R.A.M.C., to Dorothy Blake Bailey, daughter of the late John R. Bailey, Solicitor, of Mark Lane and Leatherhead.

Death.

BEACOCK.—On October 26th, John Walter Beacock, L.D.S., of Station Approach, Swanage. Aged 25.

J. J. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

CHRISTMAS will soon be upon us, and though it naturally will not be celebrated as in happier days before the war, it is still an event of note in the life of the Hospital. The Landon Out-Patient Tea will be held as usual on Christmas day, and most of the wards will have concerts during Christmas week. The niggers will, as on previous occasions, perform their rounds, and the sounds sometimes heard in the college during the evenings seem to promise that at any rate they will not prove inferior to the niggers of former years. The wards will be decorated, though not perhaps on quite the pre-war scale.

With regard to the usual entertainment by the Residents, we trust that if sufficient support is forthcoming something may be arranged for the benefit of those who during Christmas week give so much time and spend so much trouble to promote the welfare and happiness of our patients. We feel sure that the Residents, Students, and Nursing Staff will do their best to make this Christmas a happy one for those within our walls.

WE are asked to announce that early in the new year a course of six lectures will be given by Mr. Thompson and Dr. Eyre on Venereal Diseases. The first lecture will probably be on January 2nd, by Mr. Thompson on Syphilis. The attendance of any Guy's man, past or present, will be welcome. These lectures are being given in connection with a new department to treat infectious venereal cases which is being formed under the auspices of the Local Government Board and the London County Council, who will defray the expenses involved. Three clinics will be held in the evenings, genito-urinary, skin, and gynæcological. The latter department will be looked after by a qualified lady practitioner, who will also, we are glad to hear, examine all patients who apply for cards for the Guy's Lying-in Charity. The genito-urinary clinic will be mainly concerned with the treatment of gonococcal infections in the male, while the skin department will deal with chancres and syphilitic skin affections. The scheme also allows for the provision of salvarsan or its equivalents to private practitioners for their administration under certain conditions. The whole scheme, which applies not only to our own but to other big hospitals, has arisen out of the recommendations of the Royal Commission on Venereal Diseases.

IN view of our remarks in a previous issue dealing with ante-natal clinics for expectant mothers, we have received particulars from a correspondent of a Maternity and Baby Welfare

Clinic which was established by the Penge Urban District Council over a year ago. We think that the particulars of the scheme may be of sufficient interest to warrant our detailing them here.

The objects of the scheme, which was drawn up and adopted by the Council in December, 1914, are as follows:—

(*a*) To provide a centre for medical advice and treatment for necessitous children under school age.

(*b*) To give to expectant and nursing mothers advice and, in suitable cases, treatment.

(*c*) To make arrangements for the provision of midwives, or medical practitioner when considered necessary.

The Clinic is held weekly at the Town Hall on Wednesday afternoon. The Medical Officer of Health attends and is assisted by the Council's Health Visitor and the District Nurse.

The children who attend are weighed at the first attendance and then examined by the M.O.H. and particulars entered by the Card Index system. Advice as to feeding and general care is given, and cases of illness are prescribed for, or referred to a doctor if constant treatment is necessary.

The provision of milk, etc., cannot be obtained by grants from public money, and as this is a vital point, a permanent voluntary fund is most urgently needed. It is no uncommon thing for children to be brought up literally losing weight for want of food, and some *nursing* mothers are also very badly fed.

A constantly increasing attendance shows that the efforts of the Council are heartily appreciated by the mothers.

Average weekly attendance for month of September, 1915, 6; January, 1916, 12; July, 22; October, 36. Total number of attendances for 12 months, 31st October, 1915, to 31st October, 1916, was 842.

The Clinic was established under a Local Government Board Order issued to County Councils and Sanitary Authorities, dated July 30th, 1915. This order pointed out that an estimate had been laid before Parliament for a grant to be distributed by the Board in aid of the expenditure of local authorities and voluntary agencies in respect of institutions or other provision for maternity and child welfare. If a scheme is approved by the Local Government Board, grants can be obtained which cover the initial expenses and include half the salaries of health visitors and other officers engaged in the work.

There are many hundreds of such clinics already established in the United Kingdom, but there is still room for many more. Moreover the ante-natal care of expectant matters is not so well dealt with as the care of the infant. At a discussion held by the section of Obstetrics and Gynæcology of the Royal Society of Medicine in November last, it was stated by Dr. Fletcher Shaw that the death rate of infants during their mothers pregnancy was greater than among survivors in the first year of life. Abortions and miscarriages were four times as numerous as still-births. Many of these could be avoided if the mothers could be saved from syphilis and toxæmia. Where an ante-natal clinic was established the doctor must be able to supervise his pregnant patient efficiently; routine urinary tests should always be made, and if albuminuria was discovered, a further investigation should follow in order to determine its origin; he must also know whether the pelvis was contracted, whether she had syphilis, and if suffering from malnutrition whether she had such diseases as Bright's disease or tuberculosis. Midwives should be encouraged to take their patients to the clinic. Further research should be carried out in ante-natal pathology. In fact, every pregnant woman should be seen by a doctor and should then

Guy's Hospital Medical School

(UNIVERSITY OF LONDON.)

ROYAL COMMISSION ON VENEREAL DISEASES

A COURSE OF LECTURES

In connection with the new Scheme for the Treatment of Venereal Diseases will be given as follows:—

A. R. THOMPSON, Esq., Ch.M., F.R.C.S.

(Surgeon in charge of the Genito-Urinary Department, Guy's Hospital).

I. Contagious Syphilis, its Clinical Manifestations & Treatment,

On Tuesday, Jan. 2nd, and Thursday, Jan. 4th, 1917.

II. Gonorrhœa, its Clinical Manifestations and Treatment,

On Thursday, Jan. 11th, and Tuesday, Jan. 16th.

J. W. H. EYRE, Esq., M.D., M.S., F.R.S.E.

(Director of the Bacteriological Department, Guy's Hospital).

I. Clinical Pathology and Diagnosis of Syphilis (Including SOFT SORE),

On Tuesday, January 9th.

II. Clinical Pathology and Diagnosis of Gonorrhœa and its Treatment by Vaccines,

On Thursday, January 18th.

LECTURES will be given at 5 p.m. in the PHYSIOLOGICAL THEATRE.

Members of the Profession will be admitted on presentation of their card.

LONDON BRIDGE,
December, 1916.

L. BROMLEY, M.A., M.C., F.R.C.S.,
Dean.

have such supervision as her condition required.

Though practically all medical men agree that there should be provision for the ante-natal care of pregnant women, the question of how it is to be brought about is a matter of dispute. There are two alternatives. The public might be educated up to the idea of attending an ante-natal clinic voluntarily, or compulsory notification of pregnancy might be introduced. The Public Health Authorities would then be responsible for the care of pregnant women. There is much to be said in favour of the latter alternative. Although it might be at first regarded as a violation of the liberties of the subject it must be remembered that the compulsory notification of births was opposed on the same grounds. Further, it is doubtful if appeals to the lower classes would not be futile, and whether the only efficient remedy would not be considerate but firm legislation. Another point in favour of compulsory notification is that a uniform system could be established all over the country, and that the expectant mother's welfare would not be dependent on local or voluntary organisations. In our opinion the present time would be a suitable one for the institution of some such compulsory system.

The war is monopolising the attention of the press, and such a measure might be passed without exciting the storm of hostile and destructive criticism usually levelled against all reforms. Further, the present moment is one when the birth-rate is declining to an alarming degree. and when every possible measure ought to be taken to preserve the future generation. New Government offices are constantly being established under the stress of war; why not go a step further in the war against disease and death, and establish a Minister of Public Health who could relieve the already congested Local Government Board?

In little more than a fortnight we shall see no more white bread. By making only whole-meal bread there is no doubt that a greater weight of bread can be produced for a given quantity of grain. Whether its nutritive value is greatly improved seems to be still a matter of dispute. Some authorities blame the bran as exciting peristalsis, and causing a slight but undeniable catarrhal inflammation of the small intestine, so that in consequence the utilisation of the nitrogen is in effect less than with the consumption of ordinary white bread. This may be the case with weak digestions, but we can hardly believe that whole-meal bread will have much deleterious effect on a normal healthy individual. One thing, however, is clear: the bran which formerly was used as food for pigs will no longer be available for that purpose, and we must therefore expect a still further rise in the cost of bacon. Farmers all over the country agree that keeping pigs will no longer be a source of profit. We fear that none of the recent and projected legislation will have much effect on the price of food. Even in the United States it has risen to such an alarming extent that proposals are being put forward in Congress to veto the exports of foodstuffs from that country. If such a step were to be taken the shortage in this country would become still more serious.

Owing to Christmas week it is possible that our next issue, which should appear on Dec. 30th, may be a few days late. This will enable us to include a fuller account of Christmas at the Hospital and also avoid interfering with the holidays of our already hard-worked printers.

Pass List.

Society of Apothecaries of London.

At the Examination held recently, D. Ramirez was approved in Midwifery.

Medical Research in Australia.

An Institute of Research in Pathology and Medicine has been established in Melbourne in connection with the Melbourne Hospital. A spacious building has been erected at a cost of over £10,000. Applications for the office of Director of the Institute are being invited. These should be sent before January 24th, 1917, to the Agent General for Victoria, Aldwych, Strand, London, from whom full particulars can be obtained. The salary is £800 per annum, with a yearly premium of £75 for retirement in addition. The Director holds office for five years, and is eligible for re-appointment.

Honours.

Military Cross.

Temp. Capt. C. D. Pye-Smith, M.C., F.R.C.S., R.A.M.C. For conspicuous gallantry and devotion to duty. He tended and dressed the wounded under intense fire throughout the operations with great courage and determination. He has on many previous occasions done very fine work.

Capt. T. A. Townsend, R.A.M.C. For conspicuous gallantry and devotion to duty. He displayed great courage and determination in rescuing several men who had been buried under heavy fire. On three previous occasions he has done very fine work.

Mentioned in Despatches.

In a despatch received from General Sir Archibald Murray, K.C.B., Commander-in-Chief of the Egyptian Expeditionary Force, dated October 1st, dealing with operations in Egypt from June 1st to September 30th, the name of temp. Lieut. Col. H. L. Eason is mentioned.

Chevalier de l'Ordre de la Couronne.

Capt Charles F. Pedley has been decorated Chevalier de l'Ordre de la Couronne for service with the Belgian Field Hospital.

Some Diseases which have become common among Soldiers in this Country.

II.—HYSTERIA.

The purpose of this article is to help the man fresh from the hospital who takes a commission in the R.A.M.C. to recognise some common types of hysteria in soldiers, and to deal with them efficiently when he meets them.

One may safely say that in this war, which is to be won by economy, economy of personnel is the most important of all. And yet there is a certain wastage of men continually going on which can be much diminished by more skill and perseverance on the part of medical officers.

Before the war one was not encouraged to make a diagnosis of hysteria in an able-bodied man, but during the past two years the condition has become more and more prevalent among soldiers both abroad and at home. Undoubtedly the strain of continuous exposure to danger, and especially the constant repression of that instinct of flight which must exist in the bravest of men, is largely responsible for this increase. But one is also struck by the number of functional conditions met with in men who have not been abroad, and I imagine that this is not a true increase.

Hysteria was probably in peace time more common than was supposed, but in these days there is an element which tends to accentuate—or rather to perpetuate—the condition, for there cannot be the same inducement for the soldier to get well as there was for the artisan. The latter lost his work and his wages through sickness; the soldier, on the other hand, continues to get paid, does no work, and has altogether a much more comfortable time than when he is well. By this I do not mean that malingering is common among soldiers, but

that the determination of the patient to get better is a most important factor in the cure of this disorder.

Therefore, when a medical officer meets with a man in whom systematic examination fails to reveal sufficient cause for the symptoms of which he complains, before coming to the conclusion that the patient either has some obscure disease beyond his knowledge, or is a malingerer, he should consider the possibility of hysteria. Here it is worth while emphasising the fact that in the uniform suit of khaki, a man loses much of the outward expression of his individuality, and one is well repaid in examining a patient of this kind by a few preliminary questions. I think the most fruitful are the following :—

What was your work in civil life?

How much did you earn at it?

What standard were you in when you left school?

Thus, one is sometimes saved from mistaking stupidity for unwillingness, or the simpleton's desire to please for hysterical readiness to respond to suggestion, and can distinguish the man of really deficient intellect who is so ready to respond to suggestion that his symptoms may be dispelled in a few minutes' conversation without more ado. Such a man is, of course, bound to relapse, but the insight gained into his character is of great importance in estimating his future efficiency as a soldier.

Most hysterical conditions can be very successfully treated, provided that the case is diagnosed early, and that the medical officer has complete confidence in his own diagnosis. Herein lies the importance of an absolutely thorough general examination of every patient, and of the rule that one should not diagnose hysteria until one has carefully excluded the possibility of organic disease. The success or failure of the treatment depends on the persuasive power of the medical officer, and any lurking suspicion in his mind of organic disease seriously weakens that power.

In making the diagnosis, the use of a proper hammer for eliciting the jerks is a great help, and this and an ordinary pin are almost as valuable items in one's equipment as a stethoscope. In the process of exclusion the presence of the knee and Achillis jerks, and the flexor plantar response, are the most important points, to which may be added, especially in cases of paralysis following bullet wounds of the limbs, the absence of muscular wasting. One then tests for the "stigmata," which are evidence of a degree of "suggestibility considered to be pathognomonic of hysteria. The stigmata which are most easily found are the typical forms of anæsthesia and the concentric contraction of the visual fields.

The sensation of a limb is, roughly, tested first to touch and then to pin prick, proceeding from the extremities upwards, by directing the patient to close his eyes, and say "yes" every time he feels anything. One may often find analgesia to strong pin prick, where there is no loss of tactile sensation, and the distribution is typically that of the glove or stocking variety with a sharply defined upper margin encircling the limb. Hemi-anæsthesia or hemi-analgesia of one side of the trunk ending abruptly at the mid line is equally common.

The size of the visual fields is, roughly, tested as follows: "To test the patient's right eye, direct him to cover up his left, and to gaze steadily at the physician's left eye. Meanwhile the physician closes his own right eye and looks steadily at the patient's pupil, watching that the patient's eye does not wander from the fixation point. Then holding his own left hand in a plane midway between himself and the patient, and beginning almost at arm's length, he brings his hand inwards towards the middle

line, meanwhile moving his own fingers. If the patient's visual field is normal he will catch sight of the moving fingers at the same time that the physician does so. If he does not, that visual field is contracted and the physician then brings his moving fingers inwards until the patient does catch sight of them." These two signs are often found together, are easy to elicit, and of great value in diagnosis.

From the point of view of the medical officer in charge of wards in a hospital, the most important cases are those in which the hysterical symptoms are grafted upon some organic lesion, for they present greater difficulties in diagnosis, the result being that the treatment of the true condition is sometimes commenced at a stage when the patient has begun to look upon himself as a chronic invalid. Nothing is worse for a hysterical patient than unsuccessful treatment.

Here is a case to illustrate this type :—

CASE I.

A driver in the R.F.A., aged 26, was admitted to hospital for gonorrhœa; the discharge soon ceased, but he developed "gonorrhœal rheumatism," and was sent up for an opinion, having failed to improve as the result of six weeks' treatment with vaccines.

I first saw him in bed, and he was then complaining of pain in the back, hips and knees. He had no temperature, and there were no signs of inflammation in the affected joints. He resisted the least movement of either knee-joint and the right hip, was apparently tender over these joints and the sacro-iliac joints, and could not sit up without assistance owing to pain in his back. At first sight it looked as if he might have a subacute multiple arthritis involving his inter-vertebral joints.

In the investigation of his muscular power, however, it was discovered that he had very marked weakness of grip in both hands for no accountable reason. A few minutes' further examination revealed contracted visual fields, and complete loss of the sensation of pain to pin prick of the right leg reaching up to a sharply-defined line encircling the thigh above the knee. It was then found that the site of tenderness to pressure over the right hip could be made to vary with suggestion.

The condition was obviously hysterical, and on inquiry his past history was as follows :—

Standard V. at school. Labourer in civil life. Joined the army at 18 and served five years, but always as officers' servant or in the cookhouse. At outbreak of war was engaged in a raid on a house full of spies. Two days after this got pains in his legs, similar to the present condition; was diagnosed as sciatica, and invalided out of the army. Recovered, and joined his present unit after six months.

The treatment I gave him was typical of that adopted in these cases; and stress may be laid here on the importance of immediate and vigorous treatment. Many diseases tend to disappear if left alone, but hysteria does not.

It was explained to the patient that in a few days he would become perfectly well, and that the first stage in his cure would be effected by electrical treatment. He would first regain the feeling in his leg, then the power in his limbs, and at the same time the pains would disappear. He was then taken to a small room apart, and his disabilities were demonstrated before his own eyes; first, the sensory loss by sticking a pin into his leg until it bled, without his feeling it; and, secondly, the paresis by asking him to dorsiflex his ankle against resistance. Strong faradism was then applied with the wire brush, first to the skin until he not only felt it, but shouted with the pain of it. Immediately after this he could feel the pin as well on this leg as on the other. Then the same current was used to stimulate the anterior tibial group of

muscles to tetanic contraction, showing the power of his own limb.

Thus, confidence in the efficacy of the treatment was established. He was at once urged to walk, and succeeded, at first dragging himself along in a contorted posture, but rapidly improving with exhortation and rigorous exercises, so that he was fit and happy to return to duty in a week.

This was a successful "cure," but considering the history, the deficient intelligence, and the very neurotic disposition, I do not consider him the sort of man worth sending into the fighting line. Nevertheless he was saved from invalidism, and should be a useful man for garrison duty abroad.

Of all cases of paralysis seen in a command at home, 75 per cent. are functional.

The next case is valuable in showing the extent to which unshaken diagnosis and treatment may be responsible for a hysterical condition. It is quoted verbatim from the notes of the medical officer who rescued the patient and who showed him to me.

Case II.

An air mechanic in the R.F.C. had a small septic wound in the bend of the left elbow (owing to some accident in the course of his work). The whole upper arm became inflamed, and an axillary abscess had to be opened. As a result of this the arm was left motionless in a splint for three weeks. When the wounds had healed and the splint was removed the whole arm was found to be partially paralysed. The fingers could be moved slowly and the elbow could be flexed, but the movements were all extremely feeble and the arm was utterly useless. It was treated as a lesion of the brachial plexus and supported in a sling. The wrist was left extended on a splint to counteract wrist-drop, and the arm had daily treatment with massage and galvanism for three months. As it made little or no improvement, the patient was brought before a medical board for discharge from the army. On examination, there was no wasting in any of the muscles of the limb, and no contractures, the paresis affected the whole arm including the shoulder, and did not pick out any particular groups of muscles. The hand and forearm were anæsthetic, the anæsthesia ending sharply in a line drawn round the upper part of the forearm. In spite of this apparent anæsthesia (which was complete for all forms of sensation when the patient realised the significance of the test) he could tell the shape and texture of objects placed in the left hand.

The paresis was clearly functional, and the patient was told that he would be well in twenty-four hours. It was pointed out that the anæsthesia was of no consequence, and to convince him of this, it was dispelled by a few minutes' treatment with strong faradism. A few more minutes' exhortation and strong faradism applied to the muscles of the upper arms succeeded in bringing back a considerable amount of power, and the patient was assured that next morning his arm would be perfectly well. This prediction was justified, and he was sent back next day to full duty with his unit.

There are several interesting points in this case. In the first place the patient was not obviously neurotic and his paresis was due much more to the mistaken diagnosis than to any hysterical predisposition. His arm was naturally weak when it was removed from the splint in the first instance, and it remained so because he thought that the nerves were injured. For this reason once the true state of affairs was pointed out he would not be likely to relapse, and the "cure" would be permanent; whereas in a confirmed hysteric it would be quite valueless, and the patient would have appeared again in a month or so with some other hysterical

manifestation. From the point of view of national economy it is easy to see the importance of a correct diagnosis. If he had been discharged from the army with one arm totally disabled as a result of military service, he would have drawn a pension and done no work till his arm was stronger. Unless the nature of his trouble happened to be correctly diagnosed at one of the periodical examinations for the assessment of his pension, there is no reason to suppose that he would ever have recovered the use of his arm, and the longer he remained ill the more difficult it would have been to cure him.

I am afraid that this kind of case may not infrequently be found in electrical treatment rooms just as the hyterical joint cases are apt to drift to Bath or Buxton; and unless they happen to come within the ken of a professed neurologist they are likely to be invalided out of the service with a high degree of disability.

The importance of cases of the class I have quoted is obvious; their frequency may be appreciated after a few months' service as a medical officer. And I would therefore urge that every man who is about to take his medical commission should devote as much time to the study of hysteria and its treatment as to that of gun shot wounds or dysentery.

C. P. SYMONDS,
M.R.C.P., M.R.C.S.

Chapel Notices.

On Christmas Day there will be Celebration of the Holy Communion at 6, 7 and 8.45. The alms will be given to the District Nurses' Maternity Samaritan Fund. Carols will be sung at Evensong on Christmas Eve and on Sunday, December 31st.

Papers by Guy's Men.

Thomas Holmes, M.S., M.D. Lond.: Congenital cystic diseases of the kidneys.—*B.M.J.*, Dec. 2, 1916.

J. E. Spiller, L.D.S: Orthodontics in Peace and War.—*The Dental Record*, Dec., 1916.

C. D. Wallis, L.D.S.: Dental inspection of School Children in the County of West Sussex.—*Ibid.*

A Landsman with the Fleet.

V.—A DOG'S BREAKFAST.*

The wardroom is filled with the apparently dead. Climbing perilously through the wardroom hatch, slithering down the slippery ladder, I am greeted by the united snoring of three lusty organs and the odour peculiar to destroyer wardrooms after three days at sea. "Phew!" I exclaim, with an affectation of cheerfulness, "the place smells like a thieves' kitchen!" One of the figures stirs slightly in his sleep and moans. "Wake up, Joseph," I cry, "come up on deck and get some air." "Leave me alone and go away," answers the Sub, without opening his eyes, "can't you see I'm going to die?" A waft of alcoholic vapour, the malicious ghost of Plymouth gin and navy port, makes me shudder and swallow hard for a moment. The reminiscences of all the meals that were ever eaten seems to hang in the air, mingled with the smell of pipe lagging and damp American cloth. A bottle of Tabasco relish, forgotten by the steward, dances a melancholy saraband upon the table. On the floor a glass, left probably by someone in precipitate flight, scampers to and fro at every movement of the vessel. The din is terrific. Every item of movable gear on the ship seems to oscillate to its own particular measure. The glasses on the sideboard tinkle with the vibration of the propellers, the lamps overhead crash together with sickening thuds. Every now and then the stern is lifted clear of the water by the crest of a wave and falls back in the trough, rebounding again and again amid the racing of the engines and the rattle of the steering gear. For an interminable period she sheers over, the sea racing green past the scuttles on one side, the others affording a blurred glimpse of grey, wind torn clouds. The spray

* Thus, in naval slang, a wild disorder.

rattles on the deck like shrapnel bullets. Slowly she rights herself, for a moment is almost level, and then rolls in the other direction. A figure appears in the doorway, muffled to the eyes and dripping with moisture. He is enveloped in a fawn-coloured "lammy" coat, descending as far as the top of his high sea boots, and covering his head with a hood gathered into a peak at either side which gives him the appearance of a Brownie. "The lieutenant says its five minutes to four, sir," he says, with husky precision. One of the recumbent figures stirs, grunts, and composes himself to sleep again. The 'and—it is Mr. Ordinary Seaman Sims (known to intimates as Tatcho from an early tendency to baldness), advances warily and shakes the sleeper. (The Gunner is apt to be a little "short" when thus aroused.) "Five minutes to four, sir," he repeats with gentle insistence. "Damn!" says the Gunner in a mechanical tone and fishes for his oilskin and sou'wester. Following in his wake I reach "topsides" again and breathe with relief the comparatively fresh sea air. Comparatively, for with the wind in its present quarter the funnel vapours, carbon and sulphur dioxide, make the after part of the ship smell like a nitrate factory.

We are far out in the Bay, have missed our rendezvous, and are returning home disconsolate followed by a racing south-westerly gale. It is lucky, too, that it *is* following and that we are not plugging into it head on. As it is, the ship yaws and jibs, shaking herself like a two-year old mare, the stern covered again and again with tons of grey-green water as the crest of a wave overtakes her. Poised, as it seems, mountain high, her sides sloping steeply down to the waters beneath, an instant later she is in the trough surrounded by boiling floods like the magic barque in Edgar Poe's phantasy. The air is full of flying spindrift which stings the face and as it dries leaves a burning sensation. Torrents of water race along the deck, emptying themselves over the sides as she rolls. When dusk falls these waters will take on the hue of molten fire, tiny phosphorescent globules will play round your feet, glimmer and slowly fade. The stern wake, too, will become a milky way, gleaming for miles astern in evidence of our passage. But now the monotone has no relief, the sea, the ship, the sky are a uniform greyish white, the spray fills the air like a mist, sea salt settles like a blight, irritating and corroding.

A difference, truly, to those summer days and friendlier waters where we lazed for hours in glassy calms. The air so clear that objects on the skyline seemed outlined in sharp perspective, days when the sea takes on the quality of bronze, and great cumulus clouds like dream mountains linger sleepily over the molten depths. Calm and treacherous is the North Sea, capricious as a feted beauty, churlish even to those who know her best. A vast and shallow basin, nowhere does its depth exceed two score fathoms, full of banks and shoals where in certain weathers the sea breaks angrily, churning up mud and sand, of sudden fogs and strange, inhuman calms, its evil reputation is by no means unmerited. In winter the winds there veer and back with alarming suddenness, a squat Dutch trawler returning with a good catch towards Borkum may find herself being driven in the twinkling of an eye up to the dreaded Pentlands. Many a good ship founders in its shifting quicksands, and not a man the wiser till some broken spar is washed ashore, it may be months later, in the Orkneys or the rockbound Norwegian fiords. But in late July or August she can offer days of an exquisite tranquility, serene and balmy, wooing you, like the syren that she is, till you forget her faithlessness. But these great rolling breakers, gathering weight onwards from the Newfoundland banks, have none of the petulance of the North Sea storms. They are solemn and deliberate, crushing you

by their very might, so huge that even on the calmest day you feel it is only in virtue of their complaisance that you and your cockle barque are not overwhelmed. Now, angry and pursuing, no great flight of imagination is required to picture our course as a race with death, the rollers growing bigger and more fierce till we are silently seized and dragged under. As I watch, three gannet, oblivious of the tempest, cross our course astern, forging their way with a long easy motion of those powerful black-tipped wings, their bodies stretched in a perfect streamline. They are the only birds, contrary to popular conception, who venture far out into the ocean solitudes. The ordinary gull, the smaller fry, the petrels, guillemots, and puffins are rarely seen more than fifty miles from land. Occasionally a Richardson's skewer, or that mighty fisherman the black-backed gull can be seen round trawlers a hundred miles out, but in general all but coastal waters are entirely destitute of bird life. These are probably bound for Ushant, a great winter resting place, whose westward rocks are whitened with the nesting of innumerable birds.

In the falling light a Viking figure looms up, and steadies himself against the binnacle. It is the first lieutenant, making grimaces to free his face of the cake of salt acquired in four hours on the bridge. "You may thank God you're not a watchkeeper, Doc." he says. "Its getting worse, too."

"What's our course," I asked.

"North, seven east; we ought to sight the Wolf by about nine thirty. Where's that cursed steward; I want some tea?"

"Both ill, I expect. They haven't appeared since lunch; no one seemed to want any."

"That's the worst of you shore loafers. Sick as dogs at sea, and too full of beans in harbour."

"If you're talking about dogs," I retort, "have a look at Joseph in the wardroom. There's a proper dog's breakfast down below if you like."

"There always is," he says, a little sadly, "Well, so long! I'm going to turn in."

And his burly form, marred a little by an early tendency to corpulence, disappears down the hatchway leading to "Blossom Alley."*

With a sigh I resume my scrutiny of the cheerless waters. G. H. F. G.

Change of Address.

Capt. E. F. Clowes, R.A.M.C., from 50 Field Ambulance, B.E.F., to No. 1 War Hospital, Reading.

Capt. M. B. Tweed, N.Z.M.C., to No. 3 New Zealand Field Ambulance, N.Z.E.F., France.

Major A. F. Hurst, R.A.M.C., from Oxford to Officers Quarters, Netley, Hants.

G. V. Saunders, L.D.S. Eng., Ivy House, Barton Street, Gloucester.

B. Eady, L.D.S., Rose Cottage, Warminster, Wilts.

N. I. Spriggs, M.D., from 83, London Road, to 105. Princess Road, Leicester.

Capt. Robert Stout, N.Z.M.C. Headquarters, 2nd Brigade, N.Z.F. Artillery, N.Z. Division, B.E.F., France.

Lieut. A. M. Ahmad, c/o India Office, Whitehall, London, S.W.

Capt. F. Pedley, from "The Haven," Sutton, Surrey, to Tudor House Cantonments, Rangoon, Burma.

Capt. H. M. Clarke, No. 45 Casualty Clearing Station, B.E.F., France.

Books, etc., Received.

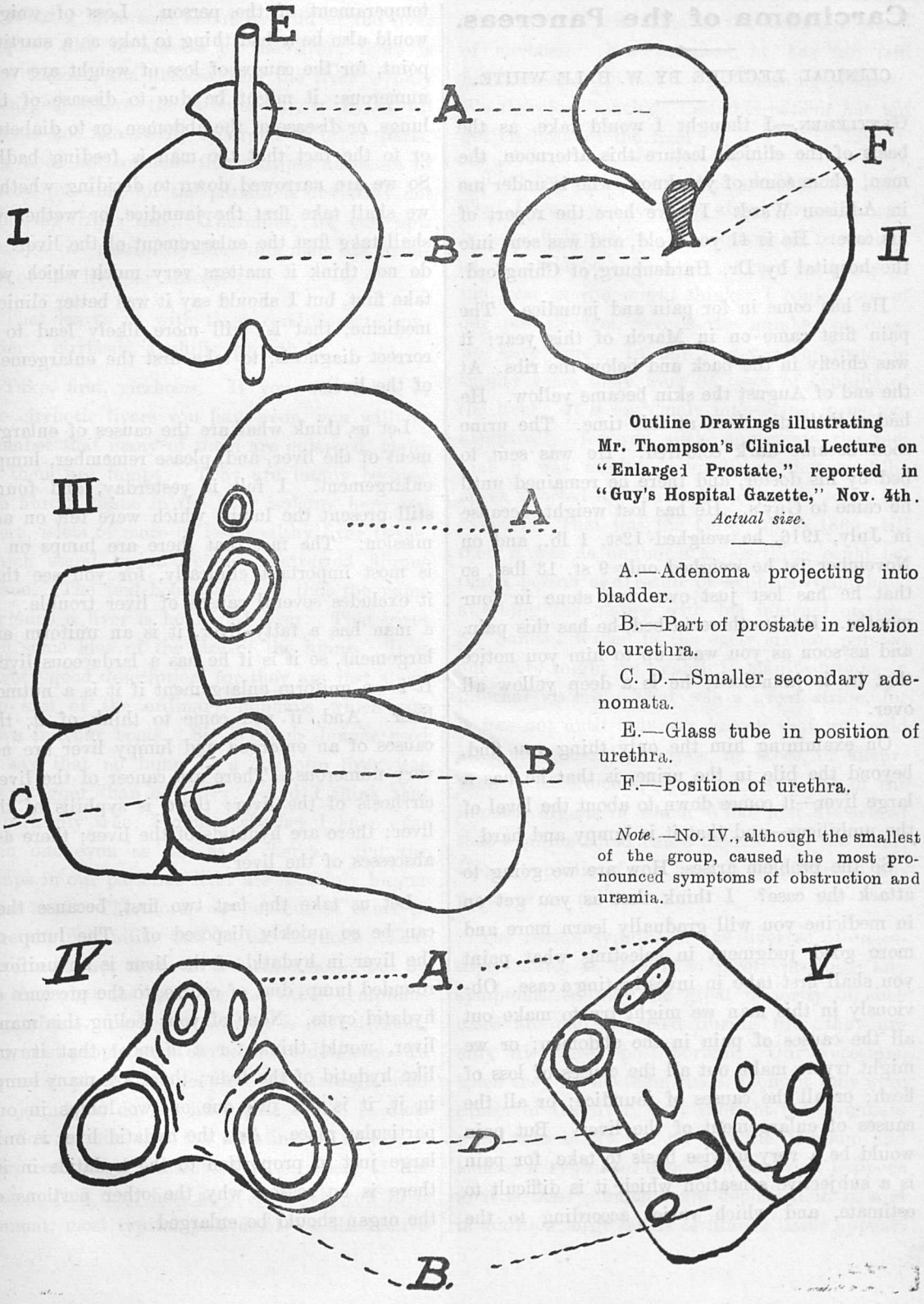
The Prescriber, New York State Journal of Medicine, The Hospital, The Samaritan Magazine, The Nursing Times (Christmas Number).

BRITISH PRISONERS OF WAR BOOK SCHEME.

Mackenzie's Diseases of the Heart. From Dr. B. Jones, M.D., Bournemouth.

Books should be addressed to the Librarian of the Wills Library, Guy's Hospital.

* The officers' quarters.



Outline Drawings illustrating Mr. Thompson's Clinical Lecture on "Enlarged Prostate," reported in "Guy's Hospital Gazette," Nov. 4th.

Actual size.

A.—Adenoma projecting into bladder.

B.—Part of prostate in relation to urethra.

C. D.—Smaller secondary adenomata.

E.—Glass tube in position of urethra.

F.—Position of urethra.

Note.—No. IV., although the smallest of the group, caused the most pronounced symptoms of obstruction and uræmia.

Carcinoma of the Pancreas.

CLINICAL LECTURE BY W. HALE WHITE.

Gentlemen,—I thought I would take, as the basis of the clinical lecture this afternoon, the man, whom some of you know, who is under me in Addison Ward. I have here the report of his case. He is 41 years old, and was sent into the hospital by Dr. Hardenburg, of Chingford.

He has come in for pain and jaundice. The pain first came on in March of this year; it was chiefly in the back and below the ribs. At the end of August the skin became yellow. He had a little diarrhœa at this time. The urine soon became dark coloured. He was sent to bed by his doctor, and there he remained until he came to Guy's. He has lost weight, because in July, 1916, he weighed 12st. 1 lb., and on November 1st he weighed only 9 st. 13 lbs., so that he has lost just over two stone in four months. He lies there in bed, he has this pain, and as soon as you walk up to him you notice that he is jaundiced; he is a deep yellow all over.

On examining him the only thing you find, beyond the bile in the urine, is that he has a large liver—it comes down to about the level of the umbilicus—and that it is lumpy and hard.

So the problem arises, How are we going to attack the case? I think that as you get on in medicine you will gradually learn more and more good judgment in selecting what point you shall first take in investigating a case. Obviously in this man we might try to make out all the causes of pain in the abdomen; or we might try to make out all the causes of loss of flesh; or all the causes of jaundice; or all the causes of enlargement of the liver. But pain would be a very unwise basis to take, for pain is a subjective sensation which it is difficult to estimate, and which varies according to the temperament of the person. Loss of weight would also be a bad thing to take as a starting point, for the causes of loss of weight are very numerous: it might be due to disease of the lungs, or disease of the abdomen, or to diabetes, or to the fact that the man is feeding badly. So we are narrowed down to deciding whether we shall take first the jaundice, or wether we shall take first the enlargement of the liver. I do not think it matters very much which you take first, but I should say it was better clinical medicine, that is, will more likely lead to a correct diagnosis, to take first the enlargement of the liver.

Let us think what are the causes of enlargement of the liver, and, please remember, lumpy enlargement. I felt it yesterday, and found still present the lumps which were felt on admission. The fact that there are lumps on it is most important clinically, for you see that it excludes several causes of liver trouble. If a man has a fatty liver, it is an uniform enlargement, so it is if he has a lardaceous liver. It is an uniform enlargement if it is a nutmeg liver. And, if you come to think of it, the causes of an enlarged and lumpy liver are not very numerous. There are cancer of the liver, cirrhosis of the liver; there is syphilis of the liver; there are hydatids of the liver; there are abscesses of the liver.

Let us take the last two first, because they can be so quickly disposed of. The lump on the liver in hydatid of the liver is an uniform rounded lump, due, of course, to the presence of hydatid cysts. None of you, feeling this man's liver, would think for a moment that it was like hydatid of the liver; there are many lumps in it, it is not just one or two lumps in one particular place. And the hydatid liver is only large just in proportion to the hydatids in it; there is no reason why the other portions of the organ should be enlarged.

What I have said about hydatid of the liver applies also to abscess of the liver; there is one tumour, the abscess, and the liver is only enlarged where the abscess is; it is, at all events not necessarily enlarged in other parts. We need not consider the multiple abscesses of portal pyæmia, for the patient is obviously not suffering from this. Therefore, we can now dismiss the possibility that this man has hydatid of the liver or abscess.

That leaves us with three conditions to consider: cirrhosis, syphilis, growth.

Take, first, cirrhosis. If you will think of the cirrhotic livers you have seen, you will remember that many of them are enlarged, many of them are lumpy. They are lumpy because the fibrous tissue in the liver isolates, here and there, islets of more or less healthy liver tissue, which stand up above the contracted fibrous tissue. The text-book tells you that the name for such a liver is hobnailed liver. That gives you some idea of the size of the lumps. It is a very good description, for they are just about the size of the ordinary hobnails which you have in your boots. Sir William Jenner used to say that no lump in a cirrhotic liver was ever bigger than a cherry. And I think that is certainly true; I doubt whether I have ever seen one even as big as a cherry. But the lumps in our patient's liver are certainly bigger than that. Therefore, we put out of court at once the possibility that he has cirrhosis. That the liver is not cirrhotic is further borne out by the fact that the man has not other symptoms of cirrhosis. To begin with, he is not a drinker, and most people with cirrhosis are drinkers. In the next place, the people with cirrhosis who are jaundiced do not have pale stools, because the flow of bile into the intestines is rarely, if ever, completely obstructed in cirrhosis of the liver. This man has, as I shall tell you in a moment, most typical pale stools of obstructive jaundice. He has none of the other symptoms of cirrhosis. For instance, he has not had hæmatemesis; he has not got morning sickness. We therefore conclude that this patient has not got cirrhosis of the liver.

That leads us to consider syphilis of the liver. That I want you to think about for a moment, because it is not in men's minds so frequently as it should be. It is not so rare a disease of the liver as you might think. I copied out of our post-mortem records the number of cases we have here. In our post-mortem room in twenty years there were 95 cases of syphilis of the liver. It is extremely interesting to us, too, historically, for you little appreciate the fact that it was taught in medicine that syphilis never affected any part of the body except the exterior. That was the belief up to 1860; till then it was as unknown as anything could be, that a person as a result of syphilis could have anything the matter with his internal organs. Sir Samuel Wilks, in the early sixties, pointed out there might be syphilitic manifestations in internal viscera. That was a great stride, for it was not until that was known that we could attribute general paralysis, or tabes, or aneurysm, or atheroma to syphilis. And one of the internal organs in which Wilks first discovered that syphilis could cause disease was the liver. Hence syphilis of the liver is of historical importance to us here.

The reason syphilis of the liver so often escapes notice is, that it so rarely produces any symptoms, so that the great majority of such cases are not suspected during life; they are only discovered post-mortem. Our ancestors, when they found these cases, thought they were cancer of the liver, they thought the gummata were cancers. If you go into the Museum and look at a syphilitic liver, you see what happens to it is this: gummata are deposited in it, and in addition large bands of fibrous tissue appear.

Syphilis has a tendency to form fibrous tissue in many places; you know the fibroid testicle of syphilis. These two adventitious growths—if one may so call them—produce extraordinary scarring of the liver, for you find here gummata and there fibrous bands forming deep depressions on the liver, and, therefore, a good example of a syphilitic liver is the most lumpy liver you can come across. One of the books compares it with a bunch of grapes. Such an extreme degree is very rarely seen, though I have seen a syphilitic liver of which that is not at all a bad description. There is no reason why a syphilitic liver should produce symptoms during life. I have never seen a case in which it caused jaundice; for all practical purposes it never does. Why should it? There is nothing pressing on the bile duct. The cause of jaundice in the case of growth of the liver is, nearly always, that the glands get affected secondarily and press on the common bile duct. But the glands in the transverse fissure of the liver are virtually never affected by gummatous deposit and enlarged. There is one specimen in one of the London museums in which the glands were affected by a gumma, with the result that the patient got jaundice. But you are safe in saying that if a man has jaundice, his case is not one of syphilis of the liver. But, you will ask, does not the enlargement attract the patient's attention? Why should it? There is no one here who could swear that his liver is not enlarged. Unless there is pain, or jaundice, or something else to attract our attention to it, we do not examine our livers. The only symptom which sometimes calls attention to the syphilitic liver is pain. In syphilis a little perihepatitis occurs over the gummata, and so there is some pain. As you would expect, the syphilitic liver is three times as common in men as it is in women, and it is usually met with between the ages of 25 and 50. There is no evidence at all that this is a syphilitic liver; indeed, we are sure it is not, because he has jaundice.

What we are now driven down to is, Is it cancer of the liver? There is much to support that view. In the first place, unfortunately, cancer of the liver is a very common disease. Here at Guy's, for example, there has been secondary cancer of the liver in 3·47 per cent. of all people who died in the hospital. Of those who die here of malignant disease, 50 per cent. have secondary deposits in the liver. Notice I said *secondary* deposits, because a primary growth in the liver is excessively rare; probably not more than 1 in 25 is primary there.

Nearly always, when there is cancer of the liver, the primary growth is at the periphery of the portal vein, which, if you think of it for a moment, will occur to you as strange. You would think that the cancer would be carried by the lymphatics, not by the veins; however, it is so. I copied down these figures to show you. In 76 cases of secondary growth of the liver the sites of the primary growth were: stomach 24, colon 12, œsophagus 10, pancreas 8, gall bladder 5, bile duct 4, appendix 1, making 64. The œsophagus, owing to the anastomosis between the portal system and the general venous system at the lower end of the œsophagus, may be taken as in the portal area, so 64 out of 76 cases were in the portal area. We will return to that point presently. That teaches us that we have got to try to find the primary growth somewhere in the portal area.

I have told you that this man's liver comes down nearly to the umbilicus, and that will remind you that the liver, when the seat of cancer, is heavier than in any other disease. The largest liver invaded with cancer I have ever come across weighed 19 lbs., but one of 33 lbs. has been recorded, which, of course, is enormous. The incidence among men and women is nearly equal, because women are more liable to ma-

lignant disease in the pelvic organs and the breasts. I have told you that hardly any cases of syphilis of the liver give symptoms; in cancer of the liver about half the cases do so, the remainder die before the symptoms appear.

Now let us see which of the symptoms of cancer of the liver our patient has. The first outstanding feature of cancer of the liver is that it frequently leads to enlargement of that organ. For it not to do so, the new growth would have to destroy liver equal in bulk to the new growth, and that it very rarely does. The liver in some of these cases, may grow so rapidly that the patient, for that reason, actually gains in weight.

When you are examining a man to see whether a tumour on the right side of the abdomen is an enlarged liver, remember that many mistakes are made in this connection; they are made by considering tumours in the neighbourhood of the liver as really belonging to the liver. For example, an extensive cancer of the stomach may be thought by the careless to be an enlarged liver; a tumour in the transverse colon may be thought to be that, too. A very common mistake, especially with beginners, is due to their forgetting that when any chronic inflammation, such as tubercle or growth, affects the omentum, it puckers the omentum up into a thickened tumour that lies across the abdomen, and, lying so near the liver, is thought to be merely an enlarged liver. So, before you decide that a tumour which you feel is enlarged liver, make sure it is not tumour of the stomach, or of the colon, or puckered omentum lying at the lower edge of the liver. It is only by percussing and feeling over the edge of the liver that you can distinguish them, but a careful examination almost invariably prevents the mistake.

Supposing that you have got so far as we have in this man, and decided that the tumour is an enlarged liver, what feature shall we notice about it? You can often see the enlargement, because the patient is wasted; you cannot in our patient. It is not uncommon to be able to stand at the edge of the bed and watch the enlarged malignant liver going up and down with respiration, the abdominal wall having become atrophied because the man is suffering from cancer. And remember that the enlargement is always downwards. Students make mistakes about that; I know from examining them. You will not get an enlargement of the liver pressing up the diaphragm unless the enlargement is something like an abscess which becomes adherent to the diaphragm, and points through it. The enlargement of the liver in cancer will take place in the direction of least resistance, which is downwards. The enlargement may occasionally be very rapid; do not be deceived by that. The man whose liver weighed 19 lbs. was in No. 2, John Ward some years ago, and he was at his work within three weeks of his death. While he was in the ward the liver increased enormously within one night. What had happened was that there had been bleeding into one of the growths, and the effusion of the blood made the enlargement more noticeable.

Pain, which you will remember our patient complained of, is a common symptom, one of the commonest, and it is due probably to a little local peritonitis over the growths.

With regard to jaundice, 50 per cent. of the people who have cancer of the liver are jaundiced. I have already explained to you that the jaundice is nearly always due to pressure on the common bile duct by enlarged glands in the transverse fissure of the liver. Occasionally a nodule of the liver itself may grow in such a direction as to press on the bile duct. You cannot remember too clearly that the commonest cause, by far, of long-lasting jaundice is cancer. I well remember, when I was a House-

Physician, and happened to be going away on a Sunday when I met at Victoria Sir James Goodhart; it was a wet, miserable morning, and very early. I wondered what brought him there so early on such a bad morning. After our mutual greetings he said, "I am going into the country, but it is a waste of time. I am going to see an old man who has had jaundice a long while. He cannot have anything but malignant disease in his liver, so I might just as well stay at home and write and tell them." And I think that is so; you will rarely find long-standing jaundice in elderly people due to anything else. And the picture of a man with long-standing jaundice due to malignant disease of the liver is one of the most characteristic in medicine.

Jaundice ultimately kills people; the bile circulating in the blood is a poison. You see, lying in bed, a wasted old man or old woman with jaundice which has lasted so long that the skin is of a yellowish olive-green, and the skin hanging in folds; and if you turn down the bedclothes you find them stained yellow by the bile which is in the urine, and you can see, through the wasted abdominal wall, the liver moving slowly up and down. And as these people die comatose, and the respiration becomes shallower and shallower, they die so slowly that really it requires a doctor to know whether they are dead or not. I have often seen these patients lying in the ward in such a condition that the untrained might have thought them dead.

Rather less than half the cases—say 40 per cent.—have ascites. The ascites is not due to —although no doubt it is accelerated by—the pressure of enlarged glands upon the portal vein, because we know from experiments that aseptic ligature of the portal vein does not lead to ascites. But remember you can hardly have cancer of the liver without its implicating the peritoneum over the liver. So, strictly speaking, most cases of cancer of the liver have cancerous peritonitis, and frequently there are scattered about, in the peritoneum, elsewhere than near the liver, other secondary nodules of cancer, so that the ascites is due to cancerous peritonitis.

Before leaving the subject of cancer of the liver I might point out to you some of the difficulties. The first difficulty is this, and it is not uncommon. Gall stones are sometimes impacted in the common duct, with the result that there is deep jaundice; and owing to the bile not being able to get into the duodenum, it is held back in the liver, consequently the liver enlarges. You may say to yourself, "Here is a patient with deep jaundice and enlargement of the liver, how am I to know whether it is gall stones impacted in the common duct, or whether it is growth?" Of course, not every case of growth in the liver makes the liver feel lumpy, because the growths might not be where we can feel them. Our patient's liver is very lumpy; we have taken that as the basis of this lecture. The problem is sometimes difficult, but I think the following points will aid you. Obviously, if the man has had attacks of gall stones before, that will be a great help. Often gall stones irritate the biliary passages and even lead to some ulceration, so that there is generally some cholecystitis as well. Therefore, a raised temperature and rigors are common when there is a stone in the common duct, especially when it has become impacted, but pyrexia is rare in cancer of the liver, and if present is slight. If the liver is lumpy, the case is one of growth, it is not one of gall stones. You will look for growths elsewhere. A man may have a growth in his rectum, or in his stomach, or other part.

I might, in passing, remind you that it is not of the vital importance which you might think, to differentiate between growth and im-

pacted gall stone. You may possibly say, "Here is an impacted gall stone; I must cut it out." But this is one of the most difficult operations in surgery. The subjects are, often, fat women, and the entrance of the duct into the duodenum lies very deep down. So it is not an operation to be undertaken lightly by anybody, and not at all by any but the skilled. You may ask, "What will happen if I do not?" Very little will happen. Impaction almost always occurs at the lower end of the common duct, where it lies obliquely in the wall of the duodenum. Almost invariably the stone ulcerates, ultimately, into the duodenum, and is passed. Death from impacted gall stones is so rare as to be a curiosity. And, inasmuch as if the case is one of growth you will not operate, you had better wait, and wait, rather than rush into an operation. I have many times seen an impacted stone removed by the surgeon, but in cases in which we were in doubt between impacted gall stone and growth, the case has always turned out to be one of growth, which seems to show that the diagnosis of impacted gall stone when definitely made is generally correctly made.

I told you earlier in the lecture that 24 times out of 25 cancer of the liver is secondary to cancer elsewhere; that in 64 out of 76 cases the cancer was at the periphery of the portal vein. Therefore, we began at once to search this man. We inquired carefully into the state of the stomach, but we could find no evidence whatever of growth there. Neither could any growth be found in the rectum. So we began to ask where the primary growth could be. In a large number of cases of growth in the liver, the primary seat of growth is in the pancreas; and that is probably so when you cannot detect a primary growth because, that organ being deep seated, it would be difficult to detect a growth there. Malignant disease of the pancreas is by no means uncommon. If you look through the *post-mortem* records here, you will find that in a quarter of the cases of disease of gross character, visible to the naked eye, in the pancreas the disease is cancer, and in those cases it is almost invariably carcinoma. It is the cause of death in 1 out of every 200 people who die here. It is commoner in men than in women, and the age is mostly between 50 and 60.

What are the symptoms of patients with cancer of the pancreas? In the first place, there is generally considerable pain. This man has a good deal of deep pain in the abdomen. Very often there is tenderness over the region of the pancreas. Sometimes you can feel a tumour in the pancreas. The reason is, that in 85 per cent. of all cases of cancer of the pancreas, the growth is in the head of the pancreas, which, as you know, is the biggest part of the gland; hence it may cause a fair-sized tumour. Sometimes I have felt one as large as my fist. In many cases the patient dies before the tumour becomes big enough for you to feel. Therefore, you have to use other means besides feeling a tumour to discover whether there is a growth in the pancreas. In some patients who are very wasted we can feel the normal pancreas, and I have known this to lead to error, because the doctor has said, "Here is a very wasted person, and I feel a lump; I believe there is a tumour in the head of the pancreas."

Sufferers from cancer of the pancreas are often sick; this man was sick. Fifty per cent. of cases of cancer of the pancreas are jaundiced, often because the liver is secondarily affected, but frequently because the cancer enlarges the head of the organ, and presses on the common duct as it passes behind the pancreas.

About one-third of the cases have ascites, because there is some malignant peritonitis as-

sociated with the cancerous disease of the head of the pancreas.

We have been able to make out that this man has some pain and tenderness, and that he has been sick; but these two facts are not enough to justify the diagnosis of malignant disease of the pancreas. They are suggestive, because we cannot find a primary seat elsewhere. Jaundice does not help us much, because that may be due to a gland in the transverse fissure of the liver.

Of late years much work has been done in trying to discover disease of the pancreas by other means. Just as I told you that syphilis was very interesting to us here because of Sir Samuel Wilks' discovery, so the examination of fæces in cases of pancreatic disease is very interesting to us here, because that marvellous observer, Bright, who seemed to observe everything, wrote a paper, as long ago as 1833, describing the kind of stools to be met with in cancer of the head of the pancreas. He describes a case in which the stool was quite white, and he said there was floating about with it a quantity of stuff like oil, which adhered to the sides of the bed-pan, clearly a great excess of fat. And we do sometimes see this great excess of fat which is so characteristic of the stools of pancreatic disease; the usual motion of a patient with pancreatic disease, there is not a visible excess of oil, but it is a very bulky motion, because it contains a mass of undigested fat. The motion is pale, because there is no bile in it. And very often the smell is distinctly disagreeable, sometimes revolting, because of the excess of fatty acids in it. Sometimes these acids are so abundant, that there is a shimmering due to the crystals. But you must remember that an increase of fat may be present in a motion without being great enough to be evident to the naked eye. So when we suspected pancreatic disease here, we asked Mr. Ryffel to examine the fæces, and I have his report here. He says it contains fatty acid crystals and fat globules, and much more fat than is normal, white, as you would expect. So that confirms our notion that the man has malignant disease of his pancreas.

Normally, a stool contains 20 to 30 per cent. of fat. It may be neutral, or free fatty acids, or it may be in the form of soaps. They say—though it is very difficult to fix the normal—that if the fat in the fæces exceeds 20 per cent. of the intake, probably there is some pancreatic disease. It is also said that if the fat in the fæces is over 30 per cent. there is probably some pancreatic disease.

As the ferment which splits up the fats cannot get into the duodenum in pancreatic disease you would expect that the quantity of unsplit fat in the fæces in these cases would be greater than in the case of the healthy. But you have to remember that the splitting up of fats is much complicated by intestinal secretions; and I do not think we can say more at present than that we have to look for an excess of fats in pancreatic disease, rather than to pay attention to the particular kind of fat present.

When we examine the motions there is something even easier to do than estimate the fat—and it is also, perhaps, more important—and that is to see whether the motion contains undigested muscle fibre. The pancreas has much to do with the digestion of protein, and if the patient has pancreatic disease you will frequently find undigested muscle fibres in the fæces. Mr. Ryffel reports that they are present here, so that is further support to the idea that our man has pancreatic disease.

Many students ask me whether a third symptom in pancreatic disease is not the presence of glycosuria. That is very rare. You will remember, from your physiology books, that for glycosuria to follow excision of the pancreas no less than four-fifths of it must be taken away. Hardly any patient survives the destruc-

tion of four-fifths of his pancreas by disease—he is dead long before that. So glycosuria, though valuable if it is present, is rare, as the patient so seldom survives long enough for it to occur.

The urine and the blood normally contain a little diastase. It was discovered, almost by accident, that in pancreatic disease the urine contains a large amount of diastase. Why, I do not know. Mr. Ryffel says the diastase in the urine of this man is 40, the normal being 10 to 20. He sums it up by saying that in relation to the fæces there is, therefore, evidence of pancreatic obstruction and inefficiency. And that is just what we expected, because we could not find any evidence of growth in any other part of the periphery of the portal vein.

One symptom of pancreatic disease, quite as curious as that of diastase, is this—and we will try it in the case of our patient before he goes out. You know that in a few people if you drop a 1 in 1,000 solution of adrenalin into the eye, the pupil will dilate. The extraordinary thing has been noted that it often happens when the patient has pancreatic disease.

To sum up, then, what we have diagnosed is that this man has malignant disease of his liver, and that it is secondary to malignant disease of the pancreas, the latter being diagnosed almost entirely by the help of Mr. Ryffel. I may add that numbers of other tests have been advocated from time to time for helping in the discovery of malignant disease of the pancreas, but those I have mentioned are the only ones which can be ordinarily employed; the others are very elaborate, or they are so uncertain as to be of no clinical value.

Lastly, coming to the prognosis, if our diagnosis is correct, the case can only have one end. The man will die in one of two ways: either he will die deeply jaundiced and comatose—the more likely—or he will die of sheer exhaustion as the result of indigestion caused by his malignant disease.

Appointments.

R.N.M.S.

Fleet Surgeon Robley H. J. Browne, who has been in East Africa and South Africa, has been appointed to the *Lion*, *vice* Maclean.

Fleet Surgeon G. E. Duncan, has been appointed to the *Vivid*, additional for disposal,

Staff-Surgeon A. W. Iredell has been appointed to the *Victory*.

R.A.M.C.

The following appointments have been made:—

Lieut.-Col. H. P. W. Barrow to be temp. Colonel whilst employed as Assistant Director of Medical Service of a Division.

Major (temp, Lieut.-Col.) R. P. Lewis to be temp. Lieut.-Col.

Capt. (temp. Major) A. S. Littlejohns to be temp. Major.

Temp. Lieuts. to be temp. Captains:—B. McDermott. W. G. S. Neely, D. R. Pike, T. H. Edey, W. D. Newland, A. G. H. Moore, E, F. Reeve, F. J, Lidderdale, E. E, Johnson, E. L. Pilbeam, S. H. Longhurst, K. C. Pitman.

To be temp. Lieuts.:—T. S. Robson, P. C. Prince, H. R. Grellet.

L. S. Pilbeam has been appointed Army Dental Surgeon with the rank of Lieutenant.

Special Reserve of Officers.

To be Lieuts.:—G. E. L. Simons, F. N. Sidebotham, J. F. Carter-Braine, G. W. Heckels.

Temp. Lieuts. relinquishing their Commissions:—H. V. Gibbons, F. S. Adams.

R.A.M.C. (Territorial).

London Sanitary Company:—G. S. Elliston to be Captain.

R.I.M.S.

A. M. Ahmad to be Lieutenant.

Civil.

I. Tewfik, M.R.C.S., L.R.C.P., has been appointed Senior Home Officer, Royal Infirmary, Chester.

S. H. Oliver, L.D.S., has been appointed Dental Clinical Assistant to King George Hospital.

GUY'S HOSPITAL ROLL OF WAR SERVICE.

1.—Medical School and Staff (Past and Present).

Further Additions and Corrections.

Ackroyd, H.	Temp. Capt.	...R.A.M.C. (Military Cross, 1916.)
Adams, M. M.	Capt. ...	...South African M.C.
Ahmad, A. M.	Lieut. ...	...I.M.S.
Alcock, J. A. M. ...	Temp. Surg.	...R.N. H.M.S. "Vivid."
Allen, G. W.	Private	...Artists' Rifles.
Anderson, R. G. ...	Major ...	...R.A.M.C. att. Egyptian Army. Order of the Nile, 3rd Class, by H.H. the Sultan of Egypt.
Atkins, John	Colonel	...A.M.S. C.M.G, 1916. (Twice mentioned in despatches.)
Bergh, V. E. D. ...	Private	...Artists' Rifles.
Bevis, S. W.	2nd Lieut.	...R.F.A. (Military Cross.)
Black, J.	Surg. Prob.	...R.N.V.R.
Booth, E. Hargrave ...		Physician to Red Cross Hosp., Hove.
Bouic, J. A.	Cadet ...	...R.F.C.
Bradnam, C. H. ...	Lieut. ...	...R.A.M.C. (Dental).
Browne, E. Gardner ...	Lieut. ...	...R.G.A. (T.F.). 1/1st London H.B.
Bullpitt, C, M. ..	Private	...Artists' Rifles.
Camp, A. F.	Temp. Lieut.	...R.A.M.C. (Dental).
Carling, W.	Capt. ...	...R.A.M.C. (T.F.), 5th Southern Gen. Hosp.
Clark, J. Kenneth ...	Capt. ...	...39th Batt., 10th Infantry Brigade.
Cock, F. W.		Anæsthetist, King George Hosp.
Cock, Stanley	Lieut. ...	...A.S.C.
Coe, W. E.	Temp. Lieut.	...R.A.M.C. (Dental).
Cook, Frank	Capt.	...R.A.M.C. (S.R.)
Cooper, R. Sefton ...		R.A.M.C.
Crapper, H. S. ...	Temp. Lieut.	...R.A.M.C. (Dental)
Cross, L. H.	Temp. Lieut.	...R.A.M.C. (Dental).
Curle, R.	Tp. Hon. Lieut.	R.A.M.C. No. 2 General Hosp., Le Havre.
Darke, S. J.	Temp. Lieut.	...R.A.M.C. (Wounded.) Military Cross.
Davidson, A.	Temp. Lieut.	...R.A.M.C. (Wounded.)
Davies, W. T. F. ...	Lieut.-Col.	...German South Africa. (Wounded.) D.S.O.
Dodd, H. G.	Capt. ...	...R.A.M.C. (T.F.). 315th Brigade, R.F.A.
Douglas, Claude G. ...	Capt. ...	...R.A.M.C. (Military Cross. Mentioned in despatches.)
Drake, H.	Temp. Lieut.	...R.A.M.C. (Dental).
Dunning, J. B. ...	Temp. Lieut.	...R.A.M.C. (Wounded.) Military Cross.
Durham, E. H. ...	Tp. Hon. Lieut.	R.A.M.C. Welsh Hosp., Netley.
Eason, H. L.	Lieut.-Col.	...R.A.M.C. (Mentioned in Despatches, Egypt, 1916.)
Elliston, G. P.	Capt. ...	...R.A.M.C. (T.F.), London Sanitary Co.
Felton, R.	Temp. Capt.	...R.A.M.C. (Military Cross.)
Francis, R. C. H. ...	Temp. Lieut.	...R.A.M.C. 20th General Hosp., France.
Franklin, R.	Temp. Lieut.	...R.A.M.C.
Fraser, F. C.	Capt. ...	...I.M.S. Mesopotamia. (Mentioned in despatches.)
Gater, A. W.	Temp. Lt.-Col.	R.A.M.C.
Gater, H J.	Temp. Capt.	...R.A.M.C. M.O., 29th Heavy Brigade, R.G.A.
German, H. B.	Temp. Capt.	...R.A.M.C., Leicester Regt. (Wounded.)
Gibbons, H. V. ...	Temp. Lieut.	...R.A.M.C.
Glover, J. A.	Temp. Capt.	...R.A.M.C.
Grellet, H. R.	Temp. Lieut.	...R.A.M.C.
Heckels, G. W. ...	Lieut. ...	...R.A.M.C. (S.R.).
Henderson, T. E. ...	2nd Lieut.	...South Staffordshire Regt. (Missing, September, 1916.)
Henry, C. J.	2nd Lieut.	...R.F.A., 1st D.A.C., B.E.F.
Hollands, W. G. ...	2nd Lieut.	...7th Batt., Royal Fusiliers. (Killed in action, October 12th, 1916.)
Hudson, E. P.	Temp. Lieut.	...R.A.M.C., R.F.A.

Jones, H. S.	Temp. Lieut. ...	R.A.M.C.
Jones, L.	Major ...	...R.A.M.C.
Lean, F. C.	Gunner	...Cornwall R.G.A.
Lidderdale, F. J. ...	Temp. Capt.	...R.A.M.C.
Lindsay, W. J. ...	Tp. Civ. Surg.	R.A.M.C. Ophth. Surg., 4th London General Hosp.
Litchfield, P. C. ...	Temp. Capt.	...R.A.M.C.
McAlpin, K. F. ...	2nd Lieut.	...
Macdonald, W. D. ...	2nd Lieut.	...Army Dental Surgeon.
Marsh, H. E.	2nd Lieut.	...R.F.A. (T.F.).
May, W. Norman ...		Civ. Surg., Officers' Section, Reading War Hosp.
Mullally, G. T. ...	Capt. ...	...R.A.M.C. (S.R.). Surgical Specialist, No. 8 C.C.S. (Mentioned in despatches.)
Ord, A. G.	Surg. Prob.	...R.N.V.R. H.M.S. "Forester."
Ordish, F. J.	Lieut.	...
Palmer, F. W. Morton	Temp. Lieut.	...R.A.M.C. No. 16 General Hosp., France.
Palmer, J. S.	2nd Lieut.	...2nd Batt., Durham L.I. (Died of wounds, October 18th, 1916.)
Pearson, J. D.	Temp. Lieut.	...R.A.M.C.
Pedley, C. F.	Surg. ...	...Belgian Field Hosp. (Chevalier de l'Ordre de la Couronne, 1916.)
Piggott, A. P.	Temp. Lieut.	...R.A.M.C.
Pitman, K. C.	Temp. Capt.	...R.A.M.C
Pollard, C. A.... ...	Major ...	...R.F.A. (Wounded.)
Poole, T. Brice ...		M.O. in charge of Overcliff Red Cross Hosp., Westcliff-on-Sea.
Prince, P. C.	Temp. Lieut.	...R.A.M.C.
Purdom, W. P. ...	Temp. Major	...R.A.M.C., in charge of F.A.
Pye-Smith, C. D. ...	Temp. Capt.	...R.A.M.C. (Military Cross, 1916.)
Rattray, M. G. ...	Temp. Lt.-Col.	R.A.M.C., in charge of F.A.
Reed, J. C. G. ...	Fleet Surg.	...R.N. H.M.S. "Thunderer."
Rees, M. J.	Temp. Capt.	...R.A.M.C. (Wounded while attending wounded under fire, and died of wounds, October 30th, 1916.)
Reeve, E. F.	Capt. ...	...R.A.M.C.
Reeve, W.		Capt., F.A. Section, National Reserve of New Zealand
Reynolds, L. L. C. ...	Lieut.Col.	...Oxford and Bucks L.I. (Wounded.) D.S.O.
Rivers, A. T.	Staff Surg.	...R.N. (Mentioned in despatches.)
Robertson, J.	Temp. Lieut.	...R.A.M.C.
Robson, T. S.	Temp. Lieut.	...R.A.M.C.
Rogerson, F.	Temp. Lieut.	...R.A.M.C.
Rowell, G.		Anæsthetist, King George Hosp., R.F.C. Hosp., etc.
Rowell, H. Ellis ...	Lieut.-Col.	...2/5th Norfolk Regt. (Territorial Decoration, July, 1916.)
Rycroft, E. C.	Temp. Lieut.	...R.A.M.C. (Dental).
Samuels, Isedon ...		Médecin Dentiste, Croix Rouge Francaise.
Samways, D. W. ...		M.O., No. 5 V.A.D. Hosp., Exeter
Scott, Maitland ...	Capt. ...	...R.A.M.C., 1st Norfolks.
Shepherd-Turneham, N. P.	Capt. ...	...Princess of Wales's Own Yorkshire Regt. (Killed in action.)
Sidebotham, F. N. ...	Lieut. ...	...R.A.M.C. (S.R.).
Simons, G. E. L. ...	Lieut. ...	...R.A.M.C. (S.R.).
Skelton, W. Bevill ...		M.O. in charge of Fort Gomer, Gosport
Smith, E.	Temp. Capt.	...R.A.M.C. (Dental).
Smyth, W. J.	Temp. Lieut.	...R.A.M.C.
Swayne, Walter C. ...	Major ...	...R.A.M.C., N.Z.F.A.
Taylor, C. L. D. ...	Temp. Lieut.	...R.A.M.C. (Dental).
Tipper, F. J.	Capt. ...	...R.A.M.C. (Dental). Inspecting Dental Officer, Eastern Command.
Townsend, T. A. ...	Capt. ...	...R.A.M.C. (T.F.), 24th London Regiment. (Military Cross.)
Tweed, M. B. M. ...	Capt. ...	...N.Z.M.C. No. 3 F.A.
Vandermin, H. F. ...	Lieut. ...	...R.A.M.C.
Vander-Spuy, D. C. ...	Private	...Artists' Rifles.
Venables, J. F. ...	Capt. ...	...R.A.M.C. M.O. in charge of Military Hosp., Swanage.
Watson, W. H. ...	Capt. ...	...South African M.C. General Hosp., Muttuga, B.E.A.
Westman, C.		R.M.O., Swedish War Hosp. for Wounded Officers, etc.
Whelpton, L. G. ...	Lieut.	...A.S.C.
Williamson, G. C. ...	2nd Lieut.	...

Correspondence.

To the Editor of Guy's Hospital Gazette.

[We would point out that we cannot *under any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

Anonymous Clinical Reports.

Sir,—May I ask you on behalf of myself and other old fogies that you would endeavour to persuade all your clinical contributors to allow you to put their full names and official positions at the beginning or end of their articles.

Several apparently very valuable contributions have recently appeared signed only by one or two sets of initials. To your own contemporaries, Sir, and to junior men about the Hospital I suspect these initials reveal the identity of the authors, and add to the interest of the communication and to the confidence in the instruction imparted. One can but admire the modesty of the authors, a quality not too common amongst us to-day, but it lessens the interest of your paper to outsiders and to—Yours truly,

Dec. 8th, 1916. AN ELDERLY GUY'S MAN.

Dear Sir,—Some months ago I designed a chassis for stretchers; I did so to obviate the necessity of our wounded lying out for hours in the fire zone. The authorities have not accepted the idea because of the difficulty of the shot-torn terrain. But I have the chassis doing nothing (it cost me £2 or £3 to have it made), and it occurred to me some Guy's man at a Field Ambulance in some far-off front might think it worth while to try it. If the cost of sending it out is not prohibitive—it is his.

It consists of wooden rollers on an iron axle; iron tretchers to keep them apart. Catches to receive the feet of a service stretcher (mark ii.) and grips to hold the stretcher and chassis in contact. The idea is to creep or crawl out to the wounded, towing the stretcher and chassis behind. It would afford less mark to the sniper than two men upright. It might be only necessary to bring the patient to the cover of a tree, a fragment of wall, or a shell-hole. The apparatus comes apart for packing; and I would send directions for putting it together.—Yours faithfully,

"Astolat," GEORGE MAHOMED.
Bournemouth.

Tetany in Children.

Sir,—Perhaps the following statement of a case of a boy about four years of age may be an object-lesson to some of your readers as a "heroic" treatment.

Called suddenly last night to a child that had been in fits for half-an-hour, I bethought me of several children that I had unfitted by the prompt administration of $CHCl_3$; consequently I was prepared. Upon arrival the conditions were the following:—Cyanosis, apparently moribund, spastic twitchings and terrible strabismus and contortions, pupils dilated,

Immediately after a few inhalations the child breathed easier, and the colour improved and twitchings diminished, until after ten or fifteen minutes all morbid symptoms passed and the colour was natural, and the child went into a calm sleep—"*exit in pace.*"

You will say, "Was I not afraid of a coroner's inquest?" No, I was not, because I had in my mind two cases—brothers 22 years of age now—at different times had apparently epileptic fits, possibly only convulsions of dentition, however, as hot bath and enemata did not *un*-fit them. I proceeded with $CHCl_3$, which soon did the trick. Naturally I was a wee bit perturbed as to the result! But now, and for a long time, I am not so.

The history of this last tetany case was that he had cabbage, etc., for his dinner, proved afterwards by his rejection of that vegetable undigested.

Treatment—Calomel gr. ij., soda and pot. brom.

To many cases in the interim have I administered $CHCl_3$ with the happiest results. The two brothers are now both serving in H.M. Army, and doing their bit for this "grand old country."—Yours truly,

Newcastle-on-Tyne, W. H. SPURGIN.
Nov. 27th, 1916.

Meeting of the Dental Societies.

An extraordinarily successful meeting of the Dental Societies was held on the evening of Tuesday, the 5th.

The subject of discussion was "A Possible Legislation of the Unqualified Man" which was most ably introduced by the Secretary, Mr. Fishburn, who spoke brilliantly for about an hour.

The discussion which followed was most interesting, and was conspicuous for a truly remarkable series of speeches from Messrs. Bull, Wright, Thorn, Gregorowski, etc., etc., some fifteen members speaking.

Progress was so rapid and enthusiastic that a compulsory conclusion had to be brought about soon after eleven o'clock.

With the exception of some of the members of the Staff, everybody of dental importance was present, both from the wards and conservation room.

A committee of the Societies' most prominent members was established to deal with proposals as to developing the decisions of the House.

Illuminating letters were read from our leading surgeons.

Guy's Hospital Physiological Society.

AT a meeting held on November 27th, a paper was read by Mr. A. G. M. Severn, on "The Localisation of the Mental Faculties."

Mr. Severn said that from time immemorial savants have endeavourod to locate the seat of the mind in the body and, although they differed on most points, they all agreed that wherever else it might be it was not in the brain. Gall was the first to place the mind in the brain. Gall was a great brain anatomist, and discovered many objectionable facts for the present day student to learn, e.g., the nuclei of the 3rd and 5th nerves.

While still a student he had noticed that linguistic powers and protruding eyes often went hand-in-hand, and he found that this was due to hypertrophy of the third frontal convolution, now known as Broca's speech area. Gall therefore located the faculty of language in this spot. Having made a start, by continual observations, clinical and post-mortem, he located 26 faculties, and his pupils have since his death mapped out the rest of the brain. Generally speaking, the higher intellectual faculties are allocated to the frontal lobe, controlling faculties to the parietal lobe, self preservation to the temporal lobe, and domestic instincts io the occipital lobe.

Some of the proofs of phrenology which Mr. Severn advanced were;—Observations on men of special genius or development in a given direction; corresponding observations on people markedly lacking in certain faculties; experiments on animal brain to localise faculties which are paralleled in the human; comparison of brain weights in mental development in races and sexes.

Physiologists have recognised some degree of cerebral localisation, but have not granted the complete localisation demanded by phrenologists. Many, while granting that the brain shapes the skull, will not allow that such small differences as occur in the size of the brain at the alleged site of the faculty can have any observable influence on the contour of the skull.

The discussion that followed was of a high standard, Mr. Severn having to endure a considerable amount of criticism, which, however, he dealt with very ably. During the debate the Chairman (Dr. Pembrey) made Mr. Severn disclose to the Society the character that an enterprising lady phrenologist had given him. We will not, however, cause Mr. Severn to blush by reproducing it here.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Trade Samples and Specialities.

Messrs. Allen & Hanburys, Ltd., forward us two brochures entitled the Allenburys' Pastilles in Throat Therapy and The Therapeutics of Oleum Morrhuæ. In these are detailed the various well-known preparations marketed by them. The composition of each preparation is given with the indications for its use. Oleum Morrhuæ is supplied either as a liquid or in capsules. "Bynol" consists of cod liver oil and malt extract, while "Bynil" Emulsion also contains Hypophosphites of Lime and Soda.

We have received a sample bottle of Gautier's Liqueur twenty-year old Brandy. It is well matured and of excellent flavour and strength, and should be admirably suited for administration in all conditions in which brandy is indicated.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Essentials of Histology. Sir Edward Schäfer. (Longmans.) Price 10s. 6d.

This eminently useful book, the last edition of which appeared a little over two years ago, has, in spite of the War and the diminished entry of medical students, reached a tenth edition, a fact which alone speaks well for its popularity. It has been thoroughly revised, but without any considerable alteration in the text or the size of the book itself. Most of the old illustrations have been retained, but a number of excellent microphotographs have been added and are of great value. One curious and notable omission, however, is that the great majority of the illustrations have no note as to either the power of the magnifications or the method of staining adopted. This could certainly be added without any increase in the size of the work, and would prove very useful to students. However, he is fortunate in having such an attractive and compact manual from which to learn the essential points in the science of Histology.

A manual of Fire Prevention and Fire Protection for Hospitals. By Otto S. Eichel, M.D., Director, Division of Sanitary Supervisors, New York State Department of Health. (Published by Messrs. Chapman and Hall, Ltd., London, 1916.) Price 4s. 6d.

This small book is intended for the use of hospital superintendents, engineers, and architects. It deals both with protection and prevention. Details of the

more useful fire extinguishers are given. It is pointed out that those provided in hospitals should be smaller than those in workshops or elsewhere in order that they may be used by women or patients in an emergency. The importance of fire drills in all big institutions is insisted on, so that everyone may know what to do. The book is an excellent summary of the elements o fire prevention and protection.

Surgical Anatomy. By John A. C. Macewen, B.Sc., M.B., C.M., Glasgow. Published by Messrs. Baillière, Tindall & Cox, London, 1916. Price, 10s. 6d. net.

This is a book of about 550 pages well illustrated with 77 coloured and plain figures. There are five sections dealing respectively with the head and neck, the thorax, the abdomen, and the lower and upper extremities. At the beginning of each section the surface anatomy of the part is dealt with, but in some cases there are no drawings to illustrate surface markings. The illustrations are derived from various sources. Many of them are taken from Buchanan's Anatomy and are admirably clear. There are also a number of very good original drawings by the author. One of these is a diagram of the abdominal wall from behind which will help students to understand inguinal and femoral herniæ.

The author has included a certain amount of physiology in the book which will make it more interesting to the beginner. It is a book which is admirably suited for use in conjunction with the ordinary text books of anatomy, and might well render the study of anatomy less irksome by showing how closely anatomy, surgery and physiology are linked together.

Rugby Football.

GUY'S v. NEW ZEALANDERS (CONVALESCENTS).

Played at Honor Oak Park, December 2nd, 1916, and although Guy's had to find many substitutes ere they got their full team together, only lost by a try, 3 points to nil, the score being registered early in the first half. Good defensive play by Guy's, special mention being made of Reitz, F. Bekker, E. A. Levisseur, Keet and Bonar, prevented any further score. Most of the men showed signs of insufficient training. The following constituted the team :—

GUY'S.—Curzon (back); Duff, Bonar, E. A. Levisseur, Keet (three-quarters); F. Bekker, C. Becket (halves); Laver, Reitz, Aspinwall, Long, Van der Merwe, Lewtas, H. J. Levisseur, Morrison (forwards).

GUY'S v. ROYAL FLYING CORPS (OXFORD).

The Hospital had quite a good side out at Honor Oak Park on Saturday for the above match, and at one time looked like running up a big score. The final total was 2 goals and 4 tries to nil; but considering the weak opposition it should have been more. Quite early in the play 3 tries were scored, one by Keet and one by Bekker, the third by a forward from the line out; two of the tries were converted by Millett. That was all the scoring in the first half. The forwards did not follow up at all as they should, showing on many occasions lack of "devil." Armstrong, Reitz and Phillips were exceptions to this. In the scrums the shoving was very feeble against so light a side. As a consequence, Levisseur could not get the ball away cleanly, and the three-quarters, especially Keet, had to pick up what chances they could.

In the second half Blacklaws, who seems to have developed useful pace, got a neat try; after Bekker and Curle had cut out the way. Then Curle himself sailed beneath the bar for a good try, worked up to by mutual good play on Blacklaws and his own part. Millett missed converting the former try. The latter was so easily placed that a goal seemed certain. However, the "placer" for Reitz to kick the goal did not know his job, and three points only resulted. Towards the end Phillips dribbled over on his own and touched down. Attempting to kick the goal from an easy position, he failed unaccountably.

If the forwards play the game a little more seriously, ann the halves give their able three-quarters plenty of chances, Guy's should develope into a scoring side. Their last line was well looked after by Millett, whose display was very finished. Total score :—

Guy's, 2 goals 4 tries	22
Royal Flying Corps, nil... ...	0

GUY'S TEAM.—H. Millett (back); E. C. Keet, G. D. Bonar, C. L. Curle, A. S. Blacklaws (three-quarters); E. A. Leviseur, F. Bekker (halves); F. W. Reitz, C. W. W. Armstrong, E. S. Phillips, J. Van Dermerwe, G. W. Aspinwall, N. B. Dreyet, P. G. Grobelaar, F. W. Lewtas.

Birth.

BAGSHAWE.—On Dec. 1st, at Limassal, Cyprus, the wife of Major Vale Bagshawe, D.S.O., R.A.M.C., of twin daughters.

Marriage.

KING—CROMAR.—At the Scotch Church, Rowal Pindi, Punjab, India, on the 15th October, 1916, by the Rev. J. Jamison, Major R. G. King, R.E., of Dera, Ismail Khan, N.W.F.P., India, to Christina M. Cromar, Matron, Visitors' Hospital, Strenegar, Kashmir, late of Guy's Hospital.

Death.

TRAVERS.—On November 24th, at London Road, St. Leonards-on-Sea, Otho Robert Travers, M.R.C.S., L.S.A., aged 64.

J. J. C.

GUY'S HOSPITAL GAZETTE.

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Passim.

BY the time these lines are in print the third Christmas of the war will be a memory only, but we venture to think that it will be a memory not less pleasant than those of former years. As usual, the Niggers began their rounds in the middle of the morning, and after a strenuous day ended up about 7 p.m. with their performance in Astley Cooper. They were appreciated by the patients and all connected with the hospital as much as ever. We cannot attempt to deal with their programme in detail, but we feel sure that never have the costumes been more effective nor the songs better rendered. The Residents nobly kept up the old custom of singing in their own wards, while most of the dressers and clerks who were not in the Niggers dined in their wards by the kind invitation of the sisters.

The Landon Out-Patient Tea gave the greatest delight to some six hundred children, who all received presents besides seeing the Niggers and eating a splendid tea. The only sad sight was the crowd of children who could not obtain tickets of admission. We are glad to hear that Guy's men, past and present, responded to the appeal for funds for the tea with the greatest liberality. We feel sure that everyone who was present felt that the money was well spent. We only wish that the accommodation was sufficient for six thousand instead of six hundred.

During the week following Christmas Day most successful ward concerts have been held, particulars of which are given in another column. In spite of the competition of war hospitals, we are glad to say that many artistes from outside the hospital were found willing to help our considerable local talent in providing excellent entertainments.

IN this issue of the GAZETTE we print a number of articles by members of the Staff on the work of their particular branches of medicine and surgery during 1916. Things move so rapidly now that it is difficult to keep up with the progress made in all branches during the year. We hope that their summaries, which must of necessity be brief, may be of interest to our readers in helping them to realise how much medicine and surgery advance from year to to year. We tender our thanks to our contributors for the trouble they have taken in writing these articles at a time when they are already so over-burdened by work.

THE arrangements for dealing with cases of fractures and dislocations have recently been modified. On the first attendance in the surgery

the patient, if not admitted, is treated by the dresser on duty under the supervision of the O.P.O. The patient is then given a special card of admission to the Fracture Department, which he will attend on the following Friday, where he will be under the care of Mr. Bromley. One dresser from each surgeon's firm, according to a rota attached to the surgery duty list, is appointed for one month as dresser in the Fracture Department.

We feel sure that the new department will be a great improvement over the old system of fracture cases being retained as private patients. In former days the surgery was unpleasantly crowded on the fracture mornings, and under the new system surgeon's dressers will have much better opportunities for studying the treatment of fractures and dislocations in a systematic manner. It is hoped that practitioners who desire a second opinion on such cases will send them up on Fridays at 12 noon to the new department.

We hear with regret that Mr. W. E. Tanner, who for over a year has held the post of R.S.O., is leaving us to join the army. We can only hope that the R.A.M.C. authorities will be able to find him a position in which his surgical skill and enthusiasm for his work will be given as wide a scope as it has had here during his tenure of office as R.S.O. We understand that the Committee of Reference has decided that the appointment of R.S.O. is not an indispensable one for the running of the hospital, and, therefore, we presume that no successor will be appointed, but Mr. Tanner's very strenuous duties will have to be divided among members of the staff who remain with us. We wish Mr. Tanner every success in his military career and trust that he may return to the hospital at the end of the war.

The annual subscriptions of many of our regular readers fall due on January 1st. We enclose with this issue a bank order form for the annual subscription of 12s. 6d. for the Gazette and Reports. By signing this form, and returning it to the Manager, Guy's Hospital Gazette Office, subscribers can avoid the inconvenience of remitting small sums annually.

Changes of address, owing to the war, are so frequent that it is difficult for our staff to keep up to date. We shall be obliged if subscribers will notify the Manager at the Gazette Office of any change of address as early as possible, in order that we may be certain that the Gazette will reach its destination.

Ward Concerts.

DORCAS AND NAAMAN.

On December 28th, Dorcas and Naaman combined to hold a successful and most enjoyable concert. The professional contributions were very much enjoyed, but in no way detracted from the appreciation of the amateur talent.

The audience showed marked enthusiasm throughout, and to this was largely due the unqualified success of the entertainment. Everyone did full justice to the admirable tea provided by Mrs. Cosmo Bonsor.

JOB.

An impromptu Concert was held in Job on Dec. 28th. Miss Kilcher very kindly brought a troupe who sang, danced, played the violin and recited excellently. General relief was felt when Miss Kilcher sang the "Long Trail," especially by Mr. Steward's House Surgeon, as it being the only song he ever tried to sing, he was spared from doing it again, so all he had to do was to announce the performers when he could remember their names, and to amuse a large group of children. Some local talent was produced after tea. The policemen and Mr. Wilson were much appreciated. The children were greatly pleased when the fat policeman dropped his padding. Hr. Hughes, though present, was unfortunately unable to sing. Three cheers were given for Sister Job, who provided an excellent tea and managed things admirably.

LAZARUS.

Friday, December 29th, saw Lazarus Ward in real Christmas garb. If Rip Van Winkle had ended his long sleep in Lazarus Ward that day he would surely have commenced singing carols.

Under the subdued light of those Old English lanterns an excellent entertainment was provided. The concert

commenced well with a number of songs that all appreciated. Then old favourites from the "Niggers" arrived. Mr. Gathergood's troupe was excellent. Then appeared the quartette, so bizarre in costume and so wealthy in melody. The "Policemen," Messrs. Forbes and Woodruffe, were inimitable, and Mr. Wilson in his usual manner brought things to a climax. Miss Snelling kindly played accompaniments during the afternoon.

After tea the entertainment continued. Mr. Harrington was greeted with much cheering on his second appearance.

To provide the last item Mr. Leviseur doffed the king's uniform, and donned those of a tramp to give his rendering of classical dancing.

So ended a concert full of eujoyment for all, especially the patients and their friends.

LYDIA.

Children's Party.

About a hundred children were collected from various wards for the Lydia Children's Party. It began with a Punch and Judy show which Mr. Steward very kindly provided. It was much appreciated by old as well as young. This was followed by tea which was enjoyed, perhaps, more by the children than the adults. When tea was over, Santa Claus appeared at a window with a large sack, climbed in and frightened a few of the younger children, but on the whole met with a fair reception. Presents were brought from behind a large Christmas tree and distributed. It was difficult to make numerous mastoids from Eyes and Job hear names, and a few of the more enterprising answered more than one name, but these little errors were rectified, Santa Claus disappeared, and the party ended with three good and well-deserved cheers for Sister Lydia, who managed things excellently.

MARTHA.

Martha concert was held on Thursday, December 28th, when a large audience spent a most enjoyable afternoon. Miss Barnett's troupe, the "Why-Nots," provided the first part of the entertainment. Then came local talent—the "quartette," with soothing lullabies, and the inimitable "policemen" with deeds of fame.

After tea the concert was continued by a troupe kindly brought from the Royal Academy of Music by Miss Russell. With a varied programme they held the large audience until it became imperative that the concert should end.

PATIENCE AND SAMARITAN.

The Patience and Samaritan concert took place on Thursday afternoon, and a very excellent programme had been arranged.

The entertainment commenced with three verses of "God Save the King," after which Mr. Bertram Mitford sang the "Admiral's Broom." Quite one of the best items of the programme were some excellent recitations by Miss Beardshaw. Two of the "Borough Policemen" amused the audience very much by singing a song, and Mr. Caldecott also treated the audience to one of his songs.

Everyone seemed to enjoy themselves very much, and Sister must be congratulated on the success with which the whole entertainment went off.

Honours.

Military Cross.

Temp. Capt. James Le Fayette Lauder, D.S.O., R.A.M.C. For conspicuous gallantry and devotion to duty. He repeatedly, with different parties of stretcher-bearers. searched the forward area under intense fire, and brought in many wounded men. He had previously done fine work.

Temp. Capt. Allen Coulter Hancock, R.A.M.C. For conspicuous gallantry and devotion to duty. He led a rescue-party in the open under heavy fire, and rescued 28 wounded men. He displayed great courage and determination throughout the operation.

Capt. Noel Humphrey Wykeham Saw, R.A.M.C., S.R. For conspicuous gallantry and devotion to duty. He worked incessantly for five days and nights tending the wounded brought in from "No Man's Land." He went out himself to direct operations connected with wounded quite regardless of heavy fire.

Mentioned in Despatches.

In a despatch received from General Sir Archibald Murray, K.C.B., Commander-in-Chief of the Egyptian Expeditionary Force, dated October 1st, and dealing with operations in Egypt from June 1st to September 30th, the name of Capt. R. B. Campion (S.R.) is mentioned.

In a despatch received from Lieut.-General G. F. Milne, C.B., D.S,O., commanding the British Salonica Army, and dated October 8th, 1916, the names of Colonel G. T. Rawnsley, C.M.G., Temp. Lieut.-Colonel G. T. Willan, and Temp. Lieut.-Colonel S. L. Pallant are given as deserving of special mention.

Papers by Guy's Men.

D. E. Robinson; Severe pain following tooth extraction due to injury to the mandibular nerve.—*Brit. Dent. Journ.*, Dec. 15th, 1916.

Herbert French, M.D., F.R.C.P.: Aortic aneurysm. —*The Medical Review*, Dec., 1916 (from the *Clinical Journal*, p. 315).

R. P. Rowlands, F.R.C.S.: Carcinoma of the colon causing intestinal obstruction.—*Ibid.* (from *Guy's Hospital Gazette*, p. 207.

War Surgery in 1916.

BY C. H. FAGGE.

WHEN attempting to jot down impressions of the lines along which 1916 has added to our knowledge in this branch of surgery, one almost reflexly starts with an effort to sum up the present surgical attitude towards the aseptic versus antiseptic controversy in wound treatment. While far-reaching claims have been made on either side by the protagonists of the opposing lines of treatment in a not too edifying or dignified newspaper controversy, it must be admitted that the ordinary operating surgeon is left much in the same state of doubt as when the war began as is shown by the passing vogue of different wound treatments, or even of the use of different methods in the various sections of the same hospital at any one time. It may denote an exceedingly shallow mentality to admit, or be rank heresy to write that during the last year nothing has been so apparent as that the type or nature of the wound inflicted, and the date at which treatment is instituted have far more influence on the ultimate normal healing than any consideration of the medium or method of its employment. Thus bullet wounds when inflicted at other than close range, if treated early do uniformly well; it is of course this type of wound which within a few hours of infliction is claimed by Sir Watson Cheyne to be capable of being rendered sterile by strong antiseptic media. Quite the reverse obtains in shell wounds, particularly if a bone is involved and the patient has to lie out for several hours or days before treatment can be instituted, and yet when really adequate drainage has been provided they will do just as well and no better in the wards of the eusol enthusiast as in those of the M.O. who uses nothing but saline either iso or hypertonic. (The writer will be the first to admit that in so many positions adequate drainage seems impossible or seems incompatible with the patient's comfort or antagonistic to the essential immobilisation of a fractured limb; it therefore often happens that in practice perfect drainage is an ideal which can hardly be obtained.) The routine use of Dakin's hypochlorite solution in one or other of its forms has claimed many adherents for months past, and these have been further stimulated by the introduction by Carrel of a rigorous procedure for its better introduction into all the crevices of shell wounds. A recent lecture by Dr. Sherman, at the Royal Society of Medicine (see Proc. of the Surg. Sect.) brought this method in detail before the notice of those working in London; briefly it may be stated to consist of the free excision of the wound edges so as to convert it into a shallow cuplike cavity into which are introduced a series of narrow tubes conveying a constant or frequently renewed stream of ·5 per cent. (*i.e.*, $\frac{1}{2}$ per cent.) hypochlorite solution of standard purity into all the pockets and crevices of the wound.

Anyone without the actual personal knowledge of a large number of cases treated by this method with exact adhesion to the routine laid down by the introducer can scarcely claim the right to view this method critically, but it is admitted that while careful adherence to the principles allows the wound to be sutured within a few days if soft parts alone are involved, yet if the wound is complicated by a fracture or wound of a joint it must be left to granulate in the same way as would be secured by other less drastic methods. It is just in these complicated cases that improvement in technique is being urgently sought for, and for which as yet it must be admitted no certain road to success has been secured.

During the past few months a certain number of early and a larger number of latent or delayed cases of tetanus have appeared in England; in this connection the authorities have done good work in issuing a memorandum upon the im-

mediate treatment of initial symptoms by large intrathecal injections of tetanus antitoxin, and while there is at present no exact experimental or clinical proof as to the anatomical path by which serum introduced in this way reaches the affected nervous tissues in less time than when injected subcutaneously or intramuscularly, the recent researches of Halliburton, supported by some clinical evidence, tend to provide a sound physiological basis for this method.

The same memorandum lays stress upon the importance of observation of initial symptoms at the earliest possible date, and specially draws attention to the valuable evidence afforded by local muscular rigidity and increased reflex response; the routine use of a second prophylactic dose of antitetanic serum a week after the first is recommended, and has since been officially ordered.

Perhaps the most valuable outcome of the War Office Committee on Tetanus has been the appointment of Inspectors in each Command, and it is to be hoped that this system may be extended to the investigation of and the instruction of medical officers in the treatment of other wide-spread war lesions.

In the early months of the war one of the most troublesome problems which harassed surgeons near the firing line was the transport of the large number of fractured femurs which had to be dealt with. It will be remembered that Mr. Mullally was much interested in this question, and told us very graphically of the unexpected degree of shock which this type of wound usually entailed. The difficulty has largely been met by the institution of "femur hospitals," reserved for those cases only, within reasonable distance of the trenches, while it is evident, from observation of such cases which have come through to England during the past few months, that greater reliance is being placed upon Thomas' knee splint or a modified Thomas' hip splint for the transport of these severe cases to the base. One of the arguments which was made use of by the advocates of immediate plating of these septic compound fractures of the femur—viz., that a safer. more comfortable transport was obtained—has now ceased to have any cogency, and this thoroughly unsound procedure has happily vanished from the practices of this year.

There was probably no branch of general surgery in which, up to the beginning of this war, less advance had been made since Hunterian days than in the knowledge of the pathology and treatment of wounds of vessels and aneurysms, if we exclude the brilliant technique of Matas in the introduction of conservative arteriorraphy, so that the frequent occurrence of vessel-injuries by modern projectiles has opened up a new chapter in the experience of most of us. Those interested in this subject will do well to absorb at leisure the very exhaustive paper which Surg.-Gen. Sir George Makins contributed to the *Journal of Surgery* of January, 1916, which, both from the wealth of material it contains, as well as owing to the clearness with which the subject is reviewed, is likely to become the classic on this question.

It is not within our power from personal experience to offer any remarks upon the primary treatment of wounds of large vessels, but it may be of interest to draw attention to an observation made in the above paper, and more recently confirmed by others, that immediate ligation of large trunks has met with less success and been followed by a greater percentage of serious complications than previous experience founded on similar operations for aneurysms of some duration had led surgeons to expect; this is no doubt due to the "want of compensation on the part of the collateral circulation."

Of the later complications of vascular wounds the most common are arterio-venous aneurysms and arterial hæmatomata or diffuse aneurysms; the saccular circumscribed aneurysm, involving the artery only, is less often met with, and it is interesting to note that when owing to the danger and difficulty of operative interference, expectant treatment has been advised, observation for some months has shown either no tendency for the swelling to increase or even some degree of effort towards spontaneous cure in a few cases. It would appear that as soon as a patient suffering from an arterial hæmatoma is placed under favourable conditions operation is advisable owing to the tendency which this type shows of suddenly enlarging, becoming infected or of giving way with serious secondary hæmorrhage; the orthodox proceeding in such cases is the free incision of the hæmatoma after the circulation has, when possible, been controlled centrally by a tourniquet and the securing of the wounded vessel.

Operations for the relief of arterio-venous aneurysms are less urgent, and when indicated owing to the annoyance caused by the bruit or thrill or because of pain and swelling of the limb distally will best be confined to the double ligature of both vein and artery unless, as our small personal experience tends to show, it is an additional safeguard to excise the sac at the same time. Secondary hæmorrhage may, as has been pointed out, result from the giving way of an arterial hæmatoma, but has by us been more commonly met with as a sudden unexpected complication in some large septic but otherwise comparatively innocuous shell wound; when it occurs in such a wound complicated by a comminuted fracture, or in a patient already much reduced by prolonged sepsis, it is, of course, of grave significance, yet it is not in these cases but in those who were not previously regarded as serious that we have found secondary hæmorrhage to be troublesome. This may appear paradoxical, but the danger has appeared to us to consist in the fact that one is inclined to deal less radically with the less serious cases, and is prone not to appreciate the seriousness of the condition until the opportunity for conservative treatment has passed, at least this has been the criticism which we feel compelled to pass upon our own cases. It is well, therefore, to insist that every case of a single severe, or even of two slight hæmorrhages, should be given an anæsthetic, and the wound thoroughly opened up; before this is done a tourniquet has no doubt been applied, and if one slight bleeding has occurred previously the wound will have been plugged. The bleeding vessel is then carefully sought for, and if found, and after removal of the tourniquet the wound remains dry, nothing further except warmth, subcutaneous or rectal saline and pituitrin may be necessary. But if the bleeding vessels cannot be found the position of affairs calls for the most careful judgment in deciding for or against an immediate amputation; there is no doubt that amputation is the safest and usually the wisest course, particularly if an adjacent joint is septic, or a compound fracture exists, or the patient's general condition is bad; one naturally regards more conservative surgery as approaching a higher ideal, yet our experience has been that it is always unsafe to attempt to deal with the situation by further plugging, and that ligature of the main artery above the wounded area is often unsuccessful and should only be undertaken in those positions such as the neck or buttock where amputation is not a possible alternative. It may be worth noting that having now opened a good many of these wounds we have not found large veins to be the usual source of the hæmorrhage; quite commonly some comparatively small arterial branch has been the only vessel secured and no further bleeding has resulted; this helps to explain how it is that

ligation of the main artery fails, for the branch from which the hæmorrhage arose may have come off from the main trunk at a much higher level. When the main artery has been found injured, or for other reasons has to be tied, the occurrence of peripheral gangrene will probably depend upon the degree of local sepsis; yet locality has some influence on this question, for some have found it more likely in the leg than in the arm, and particularly when the popliteal has been the vessel ligatured; our experience has not borne this out.

In the summer of 1915 an official enquiry of the Base Hospitals in this country was made to discover whether late amputations had often been found necessary in cases of compound fracture of the humerus and femur; it was then the opinion of at least one of the consultants on the other side that primary amputation was advisable when a compound fracture of the femur was associated with a wound of the knee-joint. During the past year one of the most vexed questions has been the right treatment of wounds of the joints, particularly those of the knee, with or without fracture of one of the adjacent bones, and with a few remarks upon this subject this article may well close. Readers of the GAZETTE will recall recently a thoughtful article on this question by Messrs. F. D Saner and O. G. Morgan; numerous other papers have appeared in British and foreign literature, and of these the articles of Col. W. H. M. Gray and Col. Fullerton advocate definite lines of treatment in certain cases. When the joint wounds are aseptic or only mildly contaminated, even if there is a coexisting fracture, the practice of Col. Gray seems to meet with considerable success; in it the septic wounds into the joint are excised, foreign bodies are removed and the wounds are sutured. By some this method has been modified by washing out the joint with saline or ether, and Col. Gray advised that the synovial membrane might be sutured and a drain left in down to the capsule when deemed necessary. It appears that the one essential for the success of this undertaking is that it should be carried out within two or three days of infliction of the wound, the sooner the better. When the joint wounds are acutely septic, with or without fracture, the problem becomes a much more difficult one, and it is over these cases that the controversy chiefly exists. The difficulty of draining the knee-joint even partially is universally admitted, and those who rely on attempting this have to foresee the repetition of the insertion of tubes to overcome the tendency of pockets to form, and further subject their patients to a long course of sepsis to be followed by the certainty of a stiff joint, and the possibility of an amputation through the thigh.

We should in fairness here state that this has hitherto been our usual practice, only deviated from on rare occasions, partly for the reason that many of our cases have been of a latent type of infection for which the more conservative method of Gray has clearly been unsuitable, and because we have not felt drawn towards the newer, shall we say more heroic, methods. When the joint is septic, but the fracture is not an important element in the case, some have advocated an erasion of the joint which may be left freely open for drainage; we have no personal experience either of the performance or after-results of this line of treatment. For the most severe cases, particularly if complicated by fracture, free excision of the joint is now being widely advocated; we believe this practice was first introduced by the French surgeons, and it has already been so often carried out that it should be possible shortly to come to some decision as to its utility. Fullerton advises that rather less than two inches of bone should be removed, and the cut surfaces widely separated and kept apart by extension on a Thomas' knee splint, so as to ensure free drainage of the intervening cavity. It would appear from Fullerton's paper (B.M.J., November 25th, 1916), which well

repays perusal, that laceration and infection of the muscles of the thigh is the chief contra-indication, and it will no doubt be allowed that should comminution extend more than some two inches from the articular surface, the removal of the affected bone will result in so great shortening of the limb that amputation would be better surgery. We have in mind when writing this a man who has recently come under our care from France with an excised knee, and four inches of shortening; sequestra are still present in the lower end of the femur, so that even now amputation is within the range of possibility. We should not, of course, judge the method on one case, and others which have come over to us have shown excellent functional limbs. Excision is clearly less serious, and apparently a reasonably certain alternative to amputation when undertaken within two or three days of the injury; for "late" cases it is less to be recommended, for six of forty-two died, two without and four after amputation, which, as a second operation, was necessary in all in thirteen of this series (Fullerton). It is, of course, only of these late cases that we, in London Base Hospitals, have experience, and we must confess that at present we see no adequate reason to depart from the closed method of Gray in mild cases, and drainage through free incisions for the more severe types, even though amputation must be admitted to be a commoner ending to the case than is desirable from the patient's or the Surgeon's point of view.

Publications Received.

Revista Odontologica (Buenos Aires), The Broadway or Westminster Hospital Gazette, The Hospital, St. Bartholomew's Hospital Journal, The Nursing Times, The Polyclinic, The Prescriber, New York State Journal of Medicine, St. Mary's Hospital Gazette, The Hospital Gazette for December, 1916, and Special Number describing two new Hospitals for Women.

Ophthalmological Work in 1916.

BY ARTHUR W. ORMOND.

AT the request of the Editor of the GAZETTE I have been asked to give a short resumé of some of the ophthalmological work done during the last twelve months. The war has made a very great difference to the status of the ophthalmic surgeon, as it has proved beyond question that he is indispensable from a military medical point of view. At the opening of the war the R.A.M.C. was extraordinarily undeveloped as regards its organization for carrying on any ophthalmic work; there were undoubtedly a few military surgeons who had an adequate knowledge of ophthalmic work, but most of these had obtained it through their connection with the Indian Medical Service. Speaking in a general sense the R.A.M.C. was totally unequipped for carrying out this branch of surgery. Owing, however, to the nature of the present warfare, wounds of the eyes form a very large proportion of wounds generally, and with the advent of the Citizen Army a very much larger and more urgent necessity arose for the services of the ophthalmic surgeon, as he was necessary to a large number of civilians who required his advice in order to make them fit for military duties. We have been accustomed to look upon the German army as being perfectly and efficiently equipped in every way, yet it is interesting to note that the position of the German army with regard to ophthalmic work at the beginning of the war was very similar to our own. An article by a German surgeon was published in the *Deutsch. med. Wochenschrift* last year, in which the writer states "Specialism, which has developed solely as the product of free competition, without State control, and without official State recognition, failed on this account at the beginning of the war to obtain consideration, as

II. Gonorrhœa, its Clinical Manifestations and Treatment,

On Thursday, Jan. 11th, and Tuesday, Jan. 16th.

J. W. H. EYRE, Esq., M.D., M.S., F.R.S.Edin.

(Director of the Bacteriological Department, Guy's Hospital).

I. Clinical Pathology and Diagnosis of Syphilis (Including SOFT SORE),

On Tuesday, January 9th.

II. Clinical Pathology and Diagnosis of Gonorrhœa and its Treatment by Vaccines,

On Thursday, January 18th.

LECTURES will be given at 5 p.m. in the PHYSIOLOGICAL THEATRE.

Members of the Profession will be admitted on presentation of their card.

LONDON BRIDGE,
December, 1916.

L. BROMLEY, M.A., M.C., F.R.C.S.,
Dean.

Guy's Hospital Medical School,

(UNIVERSITY OF LONDON.)

A Course of Six Lectures

Will be given in connection with the recommendations of the

ROYAL COMMISSION ON

VENEREAL DISEASES

BY

A. R. THOMPSON, Esq., Ch.M., F.R.C.S.

(Surgeon in charge of the Genito-Urinary Department, Guy's Hospital).

1. Contagious Syphilis, its Clinical Manifestations & Treatment,

On Tuesday, Jan. 2nd, and Thursday, Jan. 4th, 1917.

such, from the military authorities. On the whole, it was more and more drawn upon, as the necessity for it became apparent, and the need for ophthalmic surgeons proved to be above all expectation. Sight-testing is an important part of their work, and this "glass-fitting" (which is looked down upon, not only by the laity, but also by doctors) presupposes an unusual degree of special experience, while it has been a factor of enormous importance, undreamt of by the general public, in recovering for the army men exempted on account of refractive errors. By the work of oculists a whole army has become fit for field service."

Even now, as regards the British Army, the ophthalmic surgeons are being most unfairly and unjustly exploited; they have proved their necessity, but I believe that I am right in saying that so far as the London district is concerned no ophthalmic surgeon has received any higher rank than that of captain, although in almost every other branch of surgery medical men have received far higher rank and recognition.

During the last twelve months the most noticeable feature that I have observed in working at the Base Hospital is the alteration in the character of the wounds. At the beginning of the War we had a very large proportion of "through and through" wounds. By that I mean that the orbits of both eyes were damaged and destroyed by a bullet passing in at one side of the head and coming out at the other. This kind of wound of course was caused mainly by sniping, but the sniper has been effectually dealt with, and now owing to the almost constant bombardment, the wounds are due to explosions of shells, bombs, &c., by which large numbers of fragments strike the face and so very frequently damage both eyes; to-day, bullet wounds are far less common than are wounds due to explosion of shells.

In the old days ophthalmic surgeons used to teach that there was in the eye itself an area which was called the "dangerous area." This was situated in the ciliary region, that it to say, the space between the margin of the cornea and a distance of 6 mm. from that margin. It was thought that wounds in this region were more likely to produce sympathetic ophthalmia than wounds elsewhere. Owing to the war we have to recognise another area as a dangerous area, which a French surgeon has laid down as being about 2 c.m. around the edge of the orbit. I should have no difficulty in collecting one or two hundred cases which prove the truth of this statement; wounds inflicted by pieces of shell, etc., striking the bony margin of the orbit, are very fatal to vision. These are indirect wounds of the globe, and the damage is the result of vibrations being conducted through the soft parts within the orbit to the retina and choroid within the sclerotic and are not due to direct contact with the globe itself. The malar bone, or the superciliary region of the frontal (which Mr. Jacobson always explained to us had the function of protecting the eye), have, owing to the greater strength of the attack, become less efficient as defences of the globe than before, and a wounded soldier presenting himself with a smashed margin to his orbit is almost invariably found to be suffering also from a rupture of his choroid. The globe may become filled with blood or the optic nerve itself may be ruptured in addition, but the sight of many hundreds of eyes have been lost owing to these injuries involving the bony margin of the orbit.

During the last month the War Office have sent me for use at the 2nd London General Hospital one of the new ring magnets which are said to be a very great improvement on the old Haab magnet which we have possessed at Guy's for many years. Its main advantage is that the surgeon operates in a magnetic field, and he is able to use any instruments, which become for the time being magnetic, and is not dependent upon the rather coarse and crude

manipulations which were necessary in the old type of electro-magnet.

The ring magnet is oval, and the patient's head is placed inside the oval. Mr. Harrison Butler, who has had one of these magnets in use at Birmingham for several months, summarises the advantages of the ring magnet as follows :—

1. The operation can be performed upon a patient lying upon the table.

2. There is no necessity to move him when the splinter has appeared in the anterior chamber.

3. There is no necessity to use a hand magnet.

4. The power of the ring magnet at its centre is great and is under absolute control.

5. It is much easier to operate with the rods upon a motionless patient than to have to move his head this way and that before the Haab.

6. A patient sitting before the Haab may experience pain and move at the critical moment; he may even faint from the pain.

The only valid objection to the ring magnet is that the force is only considerable at the centre of the oval, in consequence the eye must be kept in the centre.

The teaching of blinded soldiers, in order that they may subsequently be capable of employment, is developing actively and satisfactorily. As ophthalmic surgeon to St. Dunstan's Hostel, I am able to follow my patients from the 2nd London General Hospital until they are fully equipped for useful employment in civilian life.

The number of men who have passed through St. Dunstan's this year is far in excess of what it was last year, and a very considerable number have already been employed and are now adding to their pensions by working as boot makers, poultry farmers, mat makers, basket makers, typewriters, masseurs, etc. At the 2nd London General Hospital we see all the stages of military ophthalmic work: the raw recruit comes to have his sight tested and to be fitted with glasses if necessary; the trained soldier to see if his vision is sufficient for the trenches; the wounded man, very often within 36 hours of receiving his injuries; the disfigured man for plastic operations of all kinds; the blinded men to be sent on to St. Dunstan's; and the pensioners who have been damaged one or two years previously.

The main operative work is drawn from about 250 beds which have been allocated to ophthalmic work and which are usually fully occupied. Plastic operations form a large percentage of the surgery, but in addition excisions, iridectomies, needlings for traumatic cataracts, removal of lachrymal sacs, squints, foreign bodies in the eye and orbit or in the cavities about the orbits are frequent; in fact, contrary to expectation, a very varied and valuable surgical experience is open to those of us who are busy in a base hospital, and it is most gratifying to record that a large percentage of cases are enabled to return to military service and many even to the front line.

Pass List.

Oxford University.

At the Final Examination for M.B., B.Ch., the following gentlemen were approved:—H. E. Bamber, W. Burridge, S. W. F. Underhill, H. St. H. Vertue.

Materia Medica.—H. G. Burford.

University of London.

M.D. Examination (Branch V., State Medicine).

At the recent examination, Robert Heywood Wilshaw was successful.

Royal College of Surgeons of England.

At the examination held November 23rd, 27th, 28th and 29th, William Edward Tanner acquitted himself satisfactorily and is entitled, subject to the approval of the Council, to the Diploma of Fellow.

Notes on Ear, Nose and Throat.

BY W. M. MOLLISON.

WAR INJURIES.

THESE notes were intended by the Editor of the GAZETTE to give an account of the progress made in Ear and Throat work during the year. I fear the war injuries must be regarded rather as a retrograde step than as an advance; destruction of tissue or function has been the result as far as the soldier is concerned, and from the point of view of the surgeon, increased experience.

In lieu of real progress, experience must be accepted, and no apology is offered for the following notes which deal briefly with the war injuries and neuroses of the ear, nose and throat.

THE EAR.

Cases of deafness are very frequent due to concussion from violent explosions. The result on the ears is either to produce an objective lesion—rupture of the drum—or to produce internal ear deafness without any objective lesion, with accompanying tinnitus in many cases. Cases of ruptured drum are probably not so serious as regards hearing as those where the drum remains intact, the violence of the concussion seems to spend itself on rupturing the membrane; nevertheless, many cases of ruptured membrane have a very high degree of permanent deafness.

The rupture produced is a very large one, involving a third or even half the membrane and its position is usually posterior or inferior. Of twelve munition workers deafened by an explosion, nine had ruptured membranes, and in all these the perforations were postero-inferior, and large, except those which were nearly healed, when the remaining perforation was near the centre of the membrane.

Suppuration is frequent in cases of ruptured membranes, because mud and dirt are driven in by the force of the explosion. Nevertheless, if the ears are treated antiseptically by syringing healing usually occurs and the hearing improves greatly.

One of the twelve cases cited above may be mentioned as of special interest. The patient was a man of 29. A violent explosion occurred twelve yards away from him towards his left side. Examination four months later showed a large perforation in the left drum with suppuration which had been present since two days after the accident. As the suppuration had continued in spite of treatment, and there was some pain and a little vertigo, a radical mastoid operation was advised. At the operation no pus was found in the mastoid process or antrum, but the incus was found lying loose in the antrum, having been dislocated by the force of the explosion; it was quite bare of mucous membrane and periosteum, and was blackened by the powder or dust of the explosion. The malleus and stapes were in position and undamaged. There seems no reason why many similar cases should not occur, and no doubt they do, but operation is not often called for and the dislocation of the incus is not discovered.

The cases in the second class are those due to concussion of the internal ear, or "war labyrinthitis," as it has been called by Dr. Got of Bordeaux. In these cases the explosion causes deafness which may be complete at first, but which gradually diminishes till the patient hears almost normally with the ear that was furthest from the explosion. The ear that was most exposed to the force of the explosion exhibits an internal ear deafness of variable degree: the perception of high notes is greatly diminished both through the air and generally through the bone, as tested with the monocord. The pa-

tients often complain of tinnitus and sometimes of slight vertigo (though in my experience this is an infrequent symptom). The prognosis to hearing is not good, though certainly great improvement follows in course of weeks or months after the injury. Dr. Got makes an important statement about the deafness that *it never increases*.

The pathology of the deafness is not known, though it is probable that before long microscopical examination of the temporal bones from some cases will be made. In the meantime, suggestions are put forward that hæmorrhage occurs in the cochlea, or in the eighth nerve, or the lesion is a central one, the auditory centres being concussed.

Cases of functional deafness occur, but usually these are bilateral, while, as has been stated above, the war labyrinth is almost always worse on one side and further some recovery takes place in the first week after the injury.

For further details of this subject the reader is referred to "The Journal of Laryngology, Rhinology, and Otology," Sept., 1916, where a translation of Dr. Got's paper is published.

One other class of deafness in connection with the war is that in connection with flying and in connection with aeroplane engine testing; the latter may be dismissed shortly, as the deafness is, no doubt, a modification of explosion deafness. It is quite usual for an aeroplane to reach a height of 2,000 feet in about five or ten minutes, and during this time the passengers are advised to swallow several times in order to open the Eustachian tubes and thus to equalise the pressure within and without the tympanum; this helps to prevent deafness. Owing to the noise of the engine, deafness is not noticed so much while in the air, but it is noticed by most flying men when they alight, though usually it passes off in a short time. This deafness is due to the rapid descent and change of air pressure on the membranes.

In some cases a nerve deafness develops, but perhaps this occurs in men whose ears were not normal previously. Work is being carried out now on aeroplane deafness, and no doubt interesting results will be published this year.

THE NOSE,

And with it the neighbouring air sinuses.

Injury to the nose not only leads to greater or lesser deformity depending on the direction and force of the injury, but often leads to nasal obstruction due to distortion of the septum or more often to adhesions between the septum and the outer wall. The obstruction can be dealt with by submucous resection of the septum or by removal of adhesions and the insertions of suitable plugs to prevent their reformation.

Injury to the nose itself gives scope for much ingenuity in the devising of plastic operations. Mr. Higgens has been using celluloid frames over which he joins flaps of skin, and has been obtaining excellent results. At another military hospital a most ingenious apparatus has been used in which bent hairpins are used as props to hold open the alæ, the pins themselves being fastened by strings to a band round the head.

Closely connected with nasal deformities are those of the lips, cheeks, and jaws, and any account would be incomplete that omitted to mention the plastic surgery being done by Cole and Bubb at King George's Hospital.

Implication of the air sinuses is frequent from bullet wounds through the face and thus through the maxillæ. Wounds about the root of the nose and orbits are very likely to damage the frontal sinuses; further the formation of adhesions between the septum and outer wall predisposes to chronic rhinitis and sinus infection. The cases at St. Dunstan's have come under my care, and in these cases where the eyes are destroyed by bullets or shell the frontal sinuses are apt to be damaged; also the roof of the orbits and the frontal lobes of the brain.

Recently in the hospital there have been two men from St. Dunstan's with subperiosteal abscess from sinus suppuration. The first was a man blinded in both eyes by direct injury from shell fragments; he had suffered from nasal discharge since. For ten days before admission he had had pain over the forehead and between the eyes, there had been some rise of temperature and some swelling over the root of the nose. Pus was seen in the nose, and there was a fluctuating tender swelling over the root of the nose and in the inner upper angle of the left orbit. Operation showed pus under the skin and pus in the left frontal sinus.

The second case was very similar; the man had lost both eyes; there was a red tender swelling over the inner margin of the right orbit. Operation showed that there had been direct injury to the right ethmoid, and there was pus in the ethmoidal cells and frontal sinus. Both made good recoveries.

Antral infection occurs also as a result of bullet or shell wounds through the maxilla. The following is a typical case. An officer was wounded through the left cheek, the piece of metal passing downwards through the antrum to lodge finally in the neck. Some time after the wound had healed he noticed an unpleasant smell in his nose and had some nasal discharge from the left side. Infection of the antrum was diagnosed and an intranasal antral operation performed. A small amount of very foul pus was found in the antrum. After a few days' syringing through the newly-made opening the patient was well.

One other case is of interest, though scarcely a sinus case. It is that of a blinded soldier who developed an abscess in the frontal lobe of the brain as a result of the passage of a piece of metal; incidentally the frontal sinus was involved.

A soldier at St. Dunstan's had been wounded by a piece of shell passing through the right orbit; his right eye had had to be excised and he was blinded in the left. While at St. Dunstan's it was noticed that he was apathetic and rather lazy and complained of headache. After a time he complained of increasing pain in the region of the *right* orbit, and he was admitted to Guy's. An X-ray plate showed the artificial eye on the right side and a piece of metal at the back of the *left* orbit. In a few days his pain increased and the right eyelid became red and eventually œdematous; he had some vomiting, too. Operation was performed; the margin of the right orbit was found fractured by the passage of the piece of metal; there was a little pus in the orbit and the dura mater of the anterior fossa was reddened and bulged down in a nipple-like projection where the bone was damaged. Incision into this projection evacuated a large amount of pus from the frontal lobe of the brain. Drainage was not perfect, and during the following ten days two or three further collections of pus were evacuated; meningitis also occurred, the cerebro-spinal fluid was cloudy and under increased pressure; however, by means of repeated lumbar punctures the patient made a good recovery. It should be added that the right frontal sinus contained polypoid mucous membrane. The abscess was no doubt due to the passage of a fragment of metal which entered in the region of the right orbit.

The Larynx.

The problems for the laryngologist presented by injury to the larynx are those of restoring the air way due to scarring. Various devices for intubating and dilating the larynx are used. These problems are mechanical; and more interesting perhaps are the neuroses due to shell shock; functional aphonia, and dumbness alone or in association with deafness. However, it is not possible here to enter into a discussion of these cases and their treatment; many of them come more correctly under the care of

the neurologist and suggestion enters largely into the treatment. Recently Major Hurst described some of these cases in the GAZETTE.

Finally, the following three cases are of war interest as demonstrating how injury or strain determines the site of the manifestation of constitutional disease, *e.g.*, syphilis or tubercle. Two of the cases were "gassed" and developed laryngeal disease and the other had influenza and frontal sinus infection demanding operation on the nose and developed a gummatous ulcer on the septum.

The first case is that of a man who was exposed to gas and liquid fire; he was scorched on his hands and apparently inhaled some fumes. Some weeks later he developed laryngeal obstruction which progressed. Examination with a mirror showed marked stenosis of the larynx, the aryteno-epiglottidean folds were fused above to such an extent as only to leave a small obliquely placed oval hole (half an inch by a third of an inch) leading into the larynx. This appearance was typical of syphilis, and examination of the blood showed a weak positive result.

The second was that of a sergeant. He was "gassed" with chlorine (?) in May, 1915 and was discharged from the army as unfit. At that time he lost his voice completely, and when examined in May, 1916, he was still very hoarse. A physician had examined him and found nothing wrong in the lungs. Examination of the larynx revealed much interarytenoid thickening, very irregular and spreading along the left cord. The Wassermann test gave a strongly positive result; treatment was instituted, but in spite of the absence of signs in the lungs, the patient eventually died of phthisis. The laryngitis may therefore have been tuberculous in spite of the Wassermann result.

The third case was that of a soldier invalided on account of frontal sinus suppuration; treatment was tedious, and eventually an intranasal frontal sinus operation was performed on the *right* side. During recovery from this, a typical gummatous ulcer developed on the left side of the septum; the patient then mentioned that he had had syphilis twelve years before, and had had only three months' treatment.

Genito-Urinary Department.

DURING the year 1916, the following gentlemen have acted as drsssers in the department:—Messrs. Underhill, Howe, Sterne-Howitt, Symons, Heath, Bamber, Laver, Cox, Gie, and Bulleid. To these gentlemen I offer my very hearty thanks for work done under very trying circumstances. I also wish to express my gratitude to the sisters in the out-patient department, the operating theatre, and the ward. Following Miss Macmanus' lead they have helped greatly in breaking down the prejudice which used to exist against the cases in the department.

During the year under review over four hundred and fifty new letters were given out at "out-patients," bringing the total for the year to over one hundred more than 1915. A certain number of interesting cases were sent up for consultation by Recruiting Medical Boards, but these did not number more than twenty, so that the increase is entirely apart from the war and is noteworthy and full of promise for the future of the department.

Amongst the most common cases coming up for treatment were gonorrhœa, hard or soft sores of the penis, strictures of the urethra, enlarged prostate, cystitis and renal conditions. A fair number of vesicle calculi were seen, for which, except in one case, lithotrity was performed with very satisfactory results. Some twelve cystoscopies were performed at "out-patients" and diagnoses made, in the majority of cases, before patients were admitted into the hospital.

Irrigation of the bladder was performed on some patients for growth and inflammation of the bladder, but the long time involved for one dresser to irrigate adequately the bladder makes the arrival of Mr. Laver's irrigation apparatus most welcome.

Far fewer cases of stricture of the urethra with retention of urine were admitted into the hospital than formerly, and it is gratifying to notice that the treatment recommended for such cases in the department is being adopted in the front surgery, viz., the free administration of laudanum and the withholding of a catheter. Dressers are much less keen than they were in assailing patients with a catheter who are suffering from dysuria, and hæmaturia possibly associated with vesical neoplasm. Only one case of sepsis following upon treatment of strictures is to be recorded. This satisfactory result is probably due to the rule whereby dressers who succeed only in drawing a little blood, when passing a catheter, must consult Mr. Thompson before proceeding further.

Arseno-Benzol Injections.—Cases with primary syphilitic sores were at once or within three days admitted into Cornelius Ward. They were allowed to have ordinary diet. The urine was always carefully tested before injection. The solution of arseno-benzol having been prepared, and the veins of the elbow rendered prominent and the skin aseptic, a needle was inserted into the vein chosen for the purpose and warm normal saline introduced. If the saline flowed freely, then the arseno-benzol solution was introduced. A rule was made for the dresser to the effect that if there was any hitch in the injection, such as failure of the fluid to flow, further proceedings were stopped. Dr. Iredell, towards the end of the year, had some very gratifying results with mercury ionisation, and his very kind advice and help is here most cordially acknowledged.

In one case intramine was injected as recommended in its advertisement. The result was fairly good, but the pain caused was so excessive that it is not proposed to use it again.

The following is a brief analysis (obtained with the aid of Messrs. Laver and Gie, and the head theatre nurse) of the cases admitted to the Out-patient section of the Genito-Urinary Department.

Nature of Disease.	Number of Cases.	Average Age.	Youngest Age.	Oldest Age.
Gonorrhœa, acute and chronic ...	86	30·6	17	60
Stricture, gonorrhœal	74	48·6	19	72
„ traumatic	7	36·6	11	53
Infective syphilis	68	30·1	17	59
Syphilis, clinical, but no positive reactions found	2	30·5	—	—
Enlarged prostate	37	66	48	83
Growth of bladder	15	59	35	75
Hydrocele	1	70	—	—
Varicocele	1	1	—	—
Renal lesions...	12	33	17	49
Balanitis	8	32·6	15	78
Incontinence of urine	4	27	14	55
Vesical calculus	5	42·2	30	55
Tuberculous testicle	2	29·5	—	—
Gravel	1	39	—	—
Undiagnosed hæmaturia	5	41	6	57
Vesico-abdominal fistula	2	—	—	—
Ureteric calculus	1	21	—	—
Sacculus of bladder...	1	25	—	—
Undescended testicle	1	13	—	—
Hypospadias	1	35	—	—
Acute retention (? cause)	2	21	—	—
Cystitis	3	37	—	—
Neurasthenia...	7	33·5	22	41
Traumatic orchitis	1	35	—	—
Rupture of urethra	1	33	—	—
Constipation and dysuria	1	56	—	—

A. R. THOMPSON.

Orthopædic Surgery.

By W. H. TRETHOWAN, F.R.C.S.

During the present year has been seen not so much the development of new orthopædic methods as the wider application of the principles and practice of this branch of surgery (and its adjuncts) to military needs. A large proportion of wounded soldiers suffer from in-

juries to the limbs, with lesions of nerves, muscles, bones, joints, etc. As a rule such cases require a very lengthy treatment, even after the primary difficulty (fracture or suppuration) has been dealt with, before the disability has been diminished enough to allow the man to return to duty, or, if relieved from further service, to resume his civilian means of livelihood. Many considerations emphasised the necessity for establishing in this, as in other branches of surgery, special hospitals, staffed by surgeons particularly interested in the work, to deal with the later and more chronic stages of deformity and disability of the limbs following injury. With the increasing demand upon the accommodation of the general military hospitals it was found impossible to keep the patients in long enough for them to obtain, by the slower methods of treatment, all possible relief from disability. It was recognised that many cases which had got over the initial effects of the injury, but had healed bent in limb, stiff in joint and tendon, or paralysed, and were too disabled to do any work, could, by special treatment in institutions provided with every facility for encouraging restoration of function, be rendered fit to return to duty, or at least to earn a living in the old or some newly-taught occupation.

Accordingly, special orthopædic hospitals were established in the largest towns throughout the country. In London, the Hammersmith Infirmary was converted into such a hospital, containing eight to nine hundred patients. Besides the purely surgical side, the accessory departments — massage, electrical, hydropathic and balneological, gymnasium, plaster, manufacture of splints and appliances, and industrial training—have been, or are being, developed to the utmost. The object of the hospital, and the system of treatment, is directed towards sending the patient back to duty, or making him fit to earn his living. In the system of training, and as an extension of the physical exercise department, the more convalescent patients are encouraged to do work in the workshops, such as carpentry, fitting, smithing, appliance making, and other metal work, tailoring, boot-making and leather work, gardening, and numerous other kinds of employment. As far as possible the manual work for each patient is so arranged that the disabled limb becomes exercised in the performance of the work. The fundamental principle of this industrial training is good, as the most beneficial physical exercise is that associated with the production of useful or interesting work. Besides, the mental effect of useful occupation is of extreme importance, and prevents the boredom which might attend protracted and slow treatment.

Many of the cases sent for treatment present unhealed sinuses, due to necrosis of bone; these are dealt with by the ordinary methods of sequestrotomy. The more active cases are confined to bed and treated by Carrel's or other method of irrigation. Intractable cases do well on packing with sulphur. Quiescent cases are allowed to get about, and massage to the parts away from the wound is permitted. Sinuses associated with fractures of the leg bones are benefited by allowing the patient to walk in an ambulatory splint; for this purpose the Thomas walking calliper splint is very useful. Open sinuses contra-indicate open operations for suture of soft parts, or for bone-plating and grafting, and usually also manipulative measures.

One of the great difficulties in war surgery is the delay in carrying out treatment by open operation, due to sepsis latent in the parts, and that of estimating when it is safe to cut down on a part without risk of lighting up the original sepsis. Greater experience has shown that many many months must elapse after the sinus has healed before a mal-united fracture can be plated, or a disorganised joint excised. Even when the proposed operation is merely on

the soft parts, *e.g.*, the suture of a nerve, a considerable interval of months must elapse before it is safe. A quiescent abscess has been found about a nerve six months after the surface wound has healed. The treatment of an old septic mal- or un-united fracture can be done at a lesser interval of time after the wound has healed if a bone graft or "bone slide" be used than if plated. Latent sepsis is a bother also in purely manipulative methods, although less so than in open operations. Wrenching of stiff joints and tendons is extremely liable to be followed by active inflammation and swelling, though not necessarily by pus formation, and, if persisted in, with or without anæsthetics, is more often than not followed by no alleviation of the stiffness. As a rule, then, it is better not to follow up the correction of a deformed joint by vigorous massage and passive movements, but to put the joint into a good position, and by means of splints to allow only very limited and restricted use. The ultimate outlook is better when this line of treatment is followed. In some cases where it is desired to obtain restoration of movement in joints badly damaged it is better to avoid movement under anæsthetic, but to alter the position of the joint daily by slow degrees, using for the purpose some jointed rack splint.

Many cases occur which call for secondary nerve suture. Exploration of the nerve is indicated when the muscles no longer react to Faradism, and evidence of reaction of degeneration exists. The response to Galvanism when R.D. is present is a peculiar sluggish or "vermiform" wave of contraction. The two ends of the nerve are freed from the scar tissue, and freshened; if there is a bulbous enlargement the distal half of this is cut away. Fine catgut through the perineurium is used for suture, and these should be as few as possible. A retaining or tension suture through the substance of the nerve ends may be temporarily or permanently necessary. Some surround the line of suture with a layer of fat, or Cargile membrane, to prevent further invasion of scar tissue. Others still use celluloid tubes. Where the loss of nerve substance is so great that the ends cannot be approximated, a bridge piece, taken from some sensory nerve or from an amputation stump, may be grafted in, to restore the anatomical continuity.

The after-treatment is begun as soon as the wound is healed. The limb is so splinted that the paralysed muscles are kept at their shortest, and the splint is not removed during treatment. For the nutrition of the muscles during the period of recovery of the nerve, electricity, massage, heat, and exercises are used. Galvanism interrupted by means of a metronome is the first electrical treatment. Later, when the muscles begin to react to Faradism, interrupted Faradism is used as well as Galvanism; both currents are used because at this stage only parts of the muscles have recovered. Later still, Faradic only is used by the method of graduated contracture. Gentle kneading massage is carried on co-incidently with the electrical treatment. Heat and warming up of the muscles always precedes other treatment. Gentle active exercises are begun as soon as the muscle is capable of any voluntary effort. As the nerve recovers, the response to Galvanism becomes normal when the Faradic response is still absent.

A peculiarity of military medical and surgical work compared with civilian practice, is the large proportion of functional or hysterical cases, and many of these find their way to the Orthopædic hospital. Some do well with moral persuasion and encouragement, assisted by electricity and massage, but usually they require more time than can well be afforded them in a busy hospital. Actual orthopædic measures — splints, plasters, tenotomies, etc.—are useless.

As regards treatment by exercises and massage, it may be said that, generally speaking, masseuses neglect exercises for massage. A great proportion of the cases require mobilisation by strong passive movements. Much too much time is spent in effleurage and kneadings. Not enough attention is paid to furthering voluntary movements, and in training co-ordination. Greater efforts should be made to obtain perfect relaxation when the voluntary movements are being exercised. No exercise should be carried to the point of fatigue, and there must be a daily graduation in the task. Useful adjuncts to massage are the "whirlpool" and "eau courant" baths. These are hot baths, from 105 to 115 degrees, where the water is in constant rapid motion, brought about by a high pressure stream flowing continuously through the bath, or by compressed air, or some mechanical means. A bath is given daily for twenty minutes, and precedes the massage.

Some Medical Work in 1916.

By E. P. POULTON, M.D.

[No attempt is made here to deal with medical work arising out of the war.]

Ascaris Lumbricoides Infection.—Hitherto it has generally been supposed that ascaris infection takes place directly from man to man by ingestion of the ripe ova. However, in the past it has proved very difficult to produce infection in animals or in man in this way. Stewart has published experiments made in Hong Kong, where ascariasis is very common, which tend to show that the mouse and rat may act as intermediate hosts. On administering the ripe ova to these animals, free larvæ emerge and are found in the fæces. Some of these larvæ pass from the alimentary canal in these animals to the liver, and from there to the lung where they set up an acute hæmorrhagic pneumonia. The larvæ then pass into the air vesicles and up the bronchi to the trachea, and it is suggested that the infected rat or mouse deposits them with its saliva on articles of food, on which the larvæ are capable of remaining alive for a short time, and in this way they gain access to the human alimentary canal and develop into the full grown worm. So far the actual transmission to man from the infected rat or mouse has not been found.

Bilharzia Infection.—Two distinct clinical types have long been recognised: the vesical, associated with hæmaturia, cystitis, and calculi; and the intestinal, associated with tenesmus, passage of blood and mucus, and formation of polypi in the rectal mucous membrane. The vesical type is usually associated with the excretion of ova having a terminal spine; in the intestinal type the ova have a lateral spine. Leiper, examining fresh-water molluscs, which act as intermediate hosts for Bilharzia worms, and subsequently infecting mice from the molluscs, has found that two kinds of ova are derived from two different species of worms, and further that these two different worms always develop in different types of mollusc. He concludes that vesical Bilharziasis produced by the Schistosoma hæmatobium is a different disease etiologically from the intestinal Bilharziasis produced by Schistosoma Mansoni.

Myocardial Degeneration.—An instrument that may prove of value in estimating degrees of myocardial degeneration has recently been introduced by Leyton. This is the Bock differential stethoscope for estimating the intensity of the cardiac sounds. The absolute intensity of the first sound at the apex, of course, varies greatly with individuals, depending on the thickness of the chest wall, the presence of emphysema, etc. However, the relative intensity of the first sound at the apex and the second sound in the aortic area are independent

of these factors, and the ratio between the two is in health about 2 to 1. In myocardial affections, whether due to degeneration or febrile conditions, the first sound becomes less intense, the two sounds getting the tic-tac quality, and the ratio becomes unity, and in some cases is reversed.

The stethoscope is furnished with an arrangement for gradually closing up the air passage between the chest wall and the ears of the observer. The amount of closure which just stops the sound from being heard is indicated by a hand moving round a dial, and gives a representation of the strength of the sound. By this means the two sounds are compared in any individual.

Artificial Pneumothorax in Phthisis. — The results of 1,028 cases obtained by 24 observers, in which the severity of the case was noted, have been published by Sachs in the "Journal of the American Medical Association." Of these cases, 88·7 per cent. were described as "advanced"; 10·6 per cent. as "moderately advanced"; cavities were present in 53 per cent.; and in 77 per cent. the disease was bilateral. In about half the cases no improvement resulted; in 29·2 per cent. there was temporary improvement, and in 21·7 per cent. there was arrest or cure.

These results indicate the importance of selecting suitable cases for treatment. It is the unilateral cases of pulmonary tuberculosis in which the treatment is indicated, because, in the words of Carson, of Liverpool, who initiated the treatment in 1821, "the diseased part would be placed in a quiescent state, receiving little or no disturbance from the movements of respiration, which would be performed solely by the other lung, and the divided surfaces would be brought into close contact by the same resilient power which before had kept them asunder."

Riviere (*Lancet*, July, 1916), gives an interesting review of the subject. It would seem that the ordinary apical phthisis is usually unsuitable for this treatment, because in the very early cases, cure by other means is possible, and in the later stages both lungs are practically always affected, and when artificial pneumothorax is performed in these cases, it is the general experience that the tuberculous process in the opposite lung progresses more rapidly than before.

The cases that do best are cases of hilus tuberculosis, in which there are often very few physical signs, and where the process spreads from the root of the lung. In dealing with these cases it does not seem to matter much if the opposite lung is also affected, provided the extent of the process is not very great. It should be mentioned that in this type of case the process is more chronic than in apical phthisis, and the prognosis better. Another important indication is hæmoptysis, especially if it is recurrent.

With regard to the operation itself, the danger is very slight, practically infinitesimal, provided the proper precautions are taken. It may be difficult to carry out successfully owing to pleural adhesions. Pleural effusions may occur with some frequency as a complication. There is considerable difference of opinion as to its effect on the progress of the case.

The Treatment of Diabetes by Fasting.—During the past year this treatment has been adopted by a number of medical men in this country. The treatment was originated by Allen at the Rockefeller Institute, and was directly based on experiments with animals. Dogs rendered diabetic by the partial extirpation of the pancreas were found to do better if starved at first, and later on allowed to eat limited quantities of food only, so that they remained thin while at the same time their urine remained sugar-free. On applying this treatment to diabetes mellitus

there is at first sight a paradox. In healthy men starvation causes the appearance of acidosis. However, in diabetes it is found that the sugar out-put diminishes, or even disappears altogether, and at the same time acidosis, as indicated by the amount of aceto-acetic, and β-oxybutyric acid also diminishes. The most probable explanation is that in diabetes, where acidosis is severe, the abnormal acids are produced from the combustion of large quantities of fat. In starvation metabolism is diminished, and so less fat is burnt and the acidosis gets less. An earlier method of treatment, initiated by Von Noorden, consisted in giving a diet deficient in caloric value—chiefly eggs and vegetables—for several days, and interspersed among these "vegetable days" were days on which large quantities of carbohydrates in the form of oatmeal or porridge were consumed. The results were often very favourable, as the sugar out-put and the acidosis were both lessened. At a meeting of the Biochemical Society, at Guy's in 1913, Hurtley showed that the beneficient effect of this treatment lay in the vegetable days, and that the days of high carbohydrate intake tended to increase both sugar and acidosis. Starting from this point, Graham, in treating diabetes among Dr. Garrod's cases at St. Bartholomew's, omitted the carbohydrate days altogether, and at the same time prescribed one or two days starvation with excellent results He thus, independently, reached somewhat the same conclusions as Allen, though at a later date. Owing to the war his results have not, so far, been published.

The essential part of Allen's treatment consists in complete starvation until the patient is sugar-free. This may last for as long as 8 or 9 days. Fluids—tea, coffee, bovril—are allowed ad lib, and alcohol if there is severe acidosis. When food is started small quantities of carbohydrates are given in the form of vegetables, such as cabbage, or lettuce, or cauliflower, and protein in the form of eggs. The diet is gradually increased, until the patient begins to pass sugar, and this gives the sugar tolerance of the individual. The patient is then starved until sugar-free, and eventually put on a diet well below the sugar tolerance as previously estimated. The protein allowed is at the rate of about 1 grm. per kilo of body weight, *i.e.*, about half the usual allowance for a normal person. When the sugar tolerance has been estimated extra fat is added to the diet till the patient ceases to lose weight. Full details of the treatment are given in the Gazette for July 15th and 29th last.

The special features of the treatment are (1) the patient must keep well below his normal weight; (2) once a week there is a starvation day, or a day of semi-starvation; (3) the patient is encouraged to look after his own diet, and to test his urine daily himself. The appearance of sugar must be at once abolished by fasting; (4) short periods of severe exercise are taken all through the treatment.

It is of course too early to give a final judgment on the value of this treatment. However, some interesting conclusions may be drawn. The patients who do best are young subjects, especially if treatment is begun as soon as the disease is first recognised. The sugar and acidosis are rapidly found to disappear, and a fairly high tolerance for carbohydrates can often be established. It is impossible to say how far the treatment will be ultimately successful in these cases, and whether the usually bad prognosis given in young subjects will prove to be unjustified. If this is the case, it will be a veritable triumph for the treatment.

In older subjects, where the prognosis is usually regarded as less grave, it is nearly always possible to make the urine sugar-free, at any rate for a time, but in many cases, especially if they are of long standing, the sugar tolerance is very low, and the patients find the continual restriction in their diet too irksome to bear. In cases where the acidosis is suffi-

cient in amount to cause anxiety, it is usually possible to lessen it by means of some modification of the treatment, though it may not be easy to keep the patient sugar-free.

One of the most hopeful aspects of the treatment is its use in cases of sepsis associated with diabetes, and it is possible that surgical interference in these cases will be less often required in the future.

Blood transfusion.—There seems little doubt, that the method of blood transfusion will be of great value in the future, for conditions of many kinds. Several ways of performing blood transfusion, have been tried, and it is impossible to say at present which will, eventually, be the one most generally used.

Direct transfusion is carried out by connecting the central end of the radial artery of the donor, to the central end of the basilic vein of the recipient, by means of a Crile's cannula, so that the blood passes in a tube lined by endothelium. Paraffined glass cannulæ have also been used. The disadvantage of the method is the length of time required for the operation, its difficulty, and the fact that there is no certain way of measuring how much passes.

In indirect methods of transfusion the blood is taken out of the vein of the donor, measured, and passed into the vein of the recipient.

In Lindeman's method, special trocars and cannulæ, are pushed into the vein of the recipient and donor; a number of syringes are sterilized and coated internally with paraffin. Each syringe is in turn filled with blood through one cannula, and emptied through the other, and rinsed out with saline; between each withdrawal and each injection the two cannulæ must be washed free of blood, by means of two more syringes, filled with saline to prevent clotting. Each syringe holds 20 cc., so that 50 injections are required in order to transfer 1,000 cc. blood, which is the amount Lindeman usually employs. There must be two operators, one for each subject, and an attendant to wash out the syringes and recoat them with paraffin at intervals. A modification of this method has been introduced by Unger, who employs one syringe connected with the two cannulæ by means of a three way tap. The blood is drawn up into the syringe through one cannula, and after turning the tap, is expelled through the other. A special device is used for washing out the cannulæ with saline.

The other methods of indirect transfusion consist of collecting blood from the veins into a vessel, and preventing coagulation by means of leech extract (hirudin), or sodium citrate, or other anti-coagulating substance. The blood is then injected into the vein of the recipient. This method is very easy to carry out. Successful results have been published by Lewisohn, Weil, and others; but Simons has published two cases of apparent poisoning, by the citrate method, so that it is impossible to be certain whether it will in the end turn out to be successful. Most observers agree that leech extract should not be employed, as different samples appear to vary as regards toxicity. In the citrate method the vein is exposed, and the blood collected through a cannula in a sterile vessel containing 25 cc., 2 per cent. sodium citrate, and thoroughly mixed up with it by means of a sterile glass rod. When 250 cc. have been collected, another 25 cc. citrate solution are added, and so on. When ready for injection the blood contains 0·2 per cent. sodium citrate.

Whatever method of transfusion be adopted there are certain precautions that should be adopted. The history of the donor should be investigated as regards syphilis, and a Wassermann reaction performed. It is also necessary to test the donor's corpuscles against the recipient's serum for agglutination and hæmolysis, and also the recipient's corpuscles against the donor's serum. In some cases sudden

attacks of pyrexia in transfusion have been shown to be due to hæmolysis. In cases of blood disease particularly, it is important to make these tests.

With regard to the indications for blood transfusions, the most obvious cases are those when the patient is suffering from sudden loss of blood owing to hæmorrhage, whether due to injury, secondary hæmorrhage, or various diseases such as typhoid, ectopic gestation, gastric or duodenal ulcer. In the latter type of case, blood transfusion actually seems to facilitate coagulation at the site of the ulcer, in spite of the rise of blood pressure. Blood transfusion seems to be valueless in cases of surgical shock. Of the blood diseases, the most notable successes have been in cases of hæmophilia. The treatment seems to be specific in its controlling effect on hæmorrhage in this disease. It has been suggested that every individual known to have hæmophilia ought to have at his command several persons whose blood has been previously shown to be compatible with his own, by means of the tests for agglutination and hæmolysis.

In pernicious and other anæmias, transfusion is useful as a palliative measure, though naturally no cure will be effected. There are possibilities with regard to its usefulness in various infective conditions, and perhaps even in cases of infective endocarditis.

Full accounts of the various methods, etc., are given in the *Journal of the American Medical Association* for 1915 and 1916. The literature is already pretty extensive.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Guy's Hospital Physiological Society.

A MEETING was held on December 11th, when there was a debate on "Food Regulations." Dr. Poulton occupied the chair.

Mr. E. E. D. Gray opened with a short talk on the present Government regulations. The main discussion following centered round standard bread and the three-course dinner. Concerning the latter, Messrs. Leviseur and FitzGerald, by their amusing descriptions of a West End seven-course dinner, endeavoured to show that it was more economical, especially with regard to meat, than the proposed three-course meal.

Mr. A. E. Sawday then introduced the following resolution:—"That no material of food value be used for the manufacture of alcohol as a beverage for the duration of the war." An interesting discussion followed, during which Mr. Leviseur astonished the Society by stating that the discipline of the Navy could not be kept unless the captain was made sufficiently "livery" in the morning as a result of his evening's bout. The motion, on being put to the vote, was carried—15 to 3.

Mr. C. H. St. John then proposed the following resolution:—"That in order to save waste and labour, no sweetstuffs be manufactured," In the debate which followod it was pointed out that pure sweets were almost essential to children. In order to accommodate for this, the resolution was amended as follows:—"In order to save labour and waste, no sweetstuffs be sold at a higher price than the value of their sugar content plus a fair percentage for the cost of manufacture retail." It was pointed out that a considerable saving in labour would result in a reduction of the consumption of sugar by adults. It was also pointed out that the male sex would save considerably when they "went west." The motion, on being put to the vote, was carried unanimously.

A proposal by Dr. Pembrey that a copy of these resolutions be sent to the Food Controller, with a resumé of the arguments brought forward in their support, was adopted by the meeting without dissent.

The meeting closed with a hearty vote of thanks to Dr. Poulton for taking the chair.

PAPERS FOR 1917.

Jan. 15.—"Alcoholism." A. E. Sawday.
" 22.—"Some Aspects of Vision." W. H. Steavenson.
" 29.—"Protective Mechanism." G. Massie and M. Cohen.
Feb. 5.—"Instinct." O. St. L. Campion.
" 12.—"Geography and Temperament." P. Couacaud and S. Rosenschein.
" 26.—"Puberty." W. Mark Brown.
Mar. 5.—"War and Physiology." K. M. Duff.
" 12.—"The Function of Leucocytes." R. Le Blanc.

Appointments.

Medical School Appointments.

JANUARY–MARCH, 1917.

Dressers or Clerks in Special Departments:—

A. *Throat & Ear, Genito-Urinary, Children.*—Messrs. L. S. Debenham, E. C. Hinde, G. Meadows, G. A. S. Shacklock.

B. *Throat & Ear, Skin, Orthopædic.*—Messrs. C. G. Coombs. T. Fernandez, O. Halstead.

C. *Eye, Nervous System.*—Messrs. W. A. Flynn, H. N. Pritchett, R. C. W. Staley.

Obstetric Dressers.—Messrs. C. W. W. Armstrong, J. R. Cox, W. R. G. Hearnden, A. Y. Massouda, H. Millett, J. Victory (Mr. Bellingham Smith); A. Bulleid, F. Caldecott, J. C. Gie, N. Kamchorn, C. H. Laver, H. J, Leviseur (Mr. Chapple).

Surgeons' Dressers.—Messrs. W. Gover, R. T. F. D. Roberts, A. G. M. Severn (Sir Arbuthnot Lane); A, R. Doyle, C. Moffatt, A. A. Osman, F. W. Reitz (Mr. Dunn); H. G. Burford, W. H. Steavenson, S. Wolff (Sir Alfred Fripp); W. H. Grace, W. A. Hawes, H. O. Long, A. L. S. Payne (Mr. Steward).

Extension Medical Ward and Post-mortem Clerks.—Messrs. G. H. FitzGerald, E. F. Kerby, A. R. Neckles, G. V. Richards (Dr. Hale White); H. F. G. Berncastle, C. G. Siggs, W. H. Simmons (Dr. Shaw); C. L. Curle, F. K. Escritt, G. M. Thomas, S. A. Withers (Dr. Fawcett); C. Gill-Carey, J. Joffe, J. E. deV. van der Merwe (Dr. Beddard).

Assistant Surgeons' Dressers.—Messrs. W. H. Cellier (Mr. Fagge); E. H. L. LeClezio, R. S. Ralph (Mr. Rowlands); G. F. Peters, T. G. D. Bonar (Mr. Hughes); G. P. Aspinwall, R. W. Warrick (Mr. Bromley).

Medical Ward Clerks (first three months).—Messrs. H. M. Brown, C. H. Horwitz, J. Kendall, L. Lavine, K. Mullen, H. W. Southgate.

Surgical Ward Clerks.—Messrs. S. T. Barrett, P. J. Briggs, K. M. K. Duff, R. B. P. Lansdown, H. S. Morris.

Pathological Assistant to Demonstrators of Morbid Anatomy.—Mr. L. S. Debenham (for six months).

Student Demonstrators of Microscopical Pathology.—Messrs. J. Victory, L. S. Debenham,*

Clinical Assistant (Fsbruary—April, 1917).—Mr. J. J. Conybeare (Dr. Hale White).

R.N.M.S.

Fleet Surgeon Robley H. Browne has been appointed to H.M.S. *Lion.*

Surgeon D. A. Mitchell, M.B., to the *Diamond.*

Surgeon F. C. Endean to the *Vivid*, additional for Plymouth Hospital.

Surg. Prob. H. W. Eddison has been appointed to H.M.S. *Saumarez.*

*For three months.

R.A.M.C.

Temp. Col. F. F. Burghard, C.B., having resigned his appointment, relinquishes his commission.

Major V. J. Crawford, D.S.O., to be temporary Lieut.-Col. whilst in command of a Field Ambulance.

Temp. Major A. H. Carter to be temp. Lieut.-Col.

Temp. Capt. G. T. S. Sichel to be temp. Major.

Temp. Lieutenants to be temp. Captains:—J. Black, J. O. Garland, S. J. Darke, S. Infield, H. B. Wilkinson, C. H. Edwards.

To be temp. Lieutenants:—J. A. C. Greene, G. H. Morris, L. S. H. Glanville, G. H. Jones.

To be temporary Hon. Lieutenant:—R. A. Chisholm, whilst employed with No. 8 British Red Cross (Baltic and Corn Exchange) Hospital.

Temp. Captain relinquishing his commission:—J. Braithwaite.

Temp. Lieutenants relinquishing their commissions:—R. G. Chase, M. Anthony.

R.A.M.C. (Territorial).

London General Hospital.—Major F. F. Burghard is restored to the Establishment.

East Lancashire Field Ambulance:—Lieut. J. Young to be Captain.

R.N.A.S.

J. A. S. Wright has been appointed Prob. Flight Officer.

S.A.M.C.

W. H. Watson to be temporary Captain.

Army Dental.

The following have been appointed Army Dental Surgeons:—A. F. A. Howe, J. H. Williams, C. D. Wood.

Temp. Lieuts. to be temp. Captains:—S. W. Charles, A. G. Forrest, A. Scott, A. J. Gwatkin.

Civil.

Capt. Frank Cook, R.A.M.C., S.R., has been appointed Hunterian Professor at the Royal College of Surgeons.

C. J. Creasy, M.R.C.S., L.R.C.P., has been appointed Certifying Surgeon for the Ringwood District, Co. Hants.

H. V. Mitchell, M.R.C.S,, L.R.C.P., has been appointed District Medical Officer of the Hartismere Union.

W. Sampson Handley, M.D., M.S. Lond., F.R.C.S. Eng., has been appointed Surgeon to the Middlesex Hospital.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Medical Diseases of the War. By A. F. Hurst, M.A., M.D., F.R.C.P. (Published by Edward Arnold, London.) Price 6s. net.

Major Hurst is admirably qualified to write on the medical diseases of the war, as he has had considerable experience as a consultant in the Mediterranean, besides having been on the staff of several base hospitals in this country. In this book, in a comparatively narrow compass, he deals with all the medical diseases which have become common among soldiers.

The longest and perhaps the most interesting chapter is on Functional Nervous Disorders. Here the author shows that though the condition of shell-shock may have an organic basis, the great majority of the striking symptoms such as blindness, deafness, or dumbness, are functional and really due to suggestion. The history of many interesting cases is given in which the results of treatment by suggestion have been highly successful. In some difficult cases the giving of an anæsthetic combined with suggestion has effected a cure.

Dysentery, both amœbic and bacillary, are fully dealt with, and there is a good chapter on Trench Fever, illustrated by a number of temperature charts.

Among the less common diseases dealt with are notes on a form of Beri-beri which occurred among the troops from Gallipoli. Dr. Hurst found that this disease was very frequently associated with attacks of epidemic jaundice, and the evidence he adduces tends to show that the disease was due to an infection of the duodenum.

We have no hesitation in saying that this is one of the most interesting books of the year, and we strongly recommend every medical man who joins the R.A.M.C. to read it.

Diseases of the Throat, Nose and Ear. By W. G Porter, M.B., B.Sc., F.R.C.S. Edin. 2nd Edition. revised by P. McBride, M.D. Edin., F.R.C.P. Edin., F.R.S. Edin. (Messrs. John Wright & Sons, Ltd, Pp. 280. Price 7s. 6d,

This book, as the author tells us in his preface to the first edition, was written for practitioners and senior students, and has been revised by Dr. P. McBride, owing to the absence of the author on active service.

The main additions to the book are the mention of the use of suspension laryngoscopy and the use of the pointing test as a diagnostic in cerebellar abscess.

This book is well written, easily read, and ought to be welcomed by those who desire a clear and concise knowledge of this subject. It contains many useful practical points and does not enter into any elaborate discussion of minor points which can be found in the larger works on this subject.

The various operations required are mentioned, but there is no minute description as to how they should be performed. There are some uncommon diseases mentioned, and these might well have been passed over so that more attention could have been paid to some of the common affections.

The ways of using the various instruments required are well described, and the various difficulties met with in using them are clearly pointed out.

The author's own diagrams are clear, but the same cannot be said of the coloured plates, and some of them might well have been omitted. There is an appendix containing various prescriptions which should prove useful.

On the whole the book is a good one, and should be welcomed by those for whom it is written.

Change of Address.

Surg. Prob. C. T. Helsham, R.N.V.R., H.M.S. *Broke*, c/o G.P.O.

Prob. Flight Officer J. A. S. Wright, R.N.A.S. Training Establishment, Crystal Palace, S.E.

Fleet Surgeon Robley H. Browne, H.M.S. *Lion*, c/o G.P.O.

S, Vidot, M.R.C.S., L.R.C.P., Chesterfield and North Derbyshire Hospital, Chesterfield.

Geoffrey Dunderdale, M.D. Lond., Colonial Medical Service, from Southwark Military Hospital, S.E., to Medical Department, Zanzibar, S. Africa.

Capt. B. R. Parmiter, M.B., B.S., R.A.M.C., from 6th Royal Irish Rifles, to 32 Field Ambulance, Salonica Force.

Major T. F. Brown, Officers' Mess, Military Hospital, Bulford Camp.

Birth.

DONNELL.—On the 15th December, at Segontium Terrace, Carnarvon, "Daisy," wife of Capt. J. H. Donnell, R.A.M.C., of Hinckley, Leicestershire, of a son.

Marriage.

CAMERON—GRIEVES.—On December 9th, at St. Michael's Church, Westoe, S. Shields, by the Rev. Mayor, John Cameron, L.D.S., Barrington Crescent, Stockton-on-Tees, youngest son of Alderman A. Cameron, J.P., to Lilian, second daughter of Mr. and Mrs. Henry Grieves, South Shields.

J. J. C.